Supreme Court, U.S.
FILED

(1)

932076 JUN 24 1994

OFFICE OF THE CLERK

No. ____

IN THE

Supreme Court of the United States

OCTOBER TERM, 1994

IN THE MATTER OF BABY K

Petition for Writ of Certiorari to the
United States Court of Appeals
For the Fourth Circuit

PETITION FOR WRIT OF CERTIORARI

Pleasant S. Brodnax, III
2861 Duke Street
Alexandria, Virginia 22314
Tel: (703) 751-1110

Kenneth E. Labowitz
YOUNG, GOLDMAN
AND VAN BEEK
510 King Street
P.O. Box 1946
Alexandria, Virginia 22313
Tel: (703) 684-3260

Counsel for Petitioners

Julia Krebs-Markrich*
John E. Coffey
Jennifer L.W. Korjus
HAZEL & THOMAS, P.C.
3110 Fairview Park Drive
Suite 1400
Falls Church, Virginia 22042
Tel: (703) 641-4200

**Counsel of Record*

Balmar Legal Publishing Services, Washington,D.C., (202) 682-9800

81 pp

QUESTION PRESENTED

1. Whether the Emergency Medical Treatment and Active Labor Act, 42 U.S.C. § 1395dd, overrides professionally accepted standards of medical care by requiring a hospital and its physicians to provide particular medical interventions to a dying child upon the demand of a parent when, in the reasonable medical judgment of the physicians, the intervention sought by the parent is medically inappropriate and unethical?

RULE 29.1 LISTING

Baby K, through her guardian *ad litem*, was the appellant in Case No. 93-1924 before the Fourth Circuit Court of Appeals.

The Hospital is an unincorporated division of Inova Health System Hospitals, which, in turn, is a subsidiary of Inova Health System Foundation. Both Inova Health System Hospitals and Inova Health System Foundation are Virginia corporations. The Hospital was the appellant in Case No. 93-1899L before the Fourth Circuit Court of Appeals.

Mr. K is the father of Baby K and was the appellant in Case No. 93-1923 before the Fourth Circuit Court of Appeals.

Ms. H is the mother of Baby K and was the appellee in Case Nos. 93-1899L, 93-1923 and 93-1924 before the Fourth Circuit Court of Appeals.

TABLE OF CONTENTS

	Page
QUESTION PRESENTED	i
RULE 29.1 LISTING	ii
OPINIONS BELOW	1
JURISDICTION	2
STATUTES INVOLVED	2
STATEMENT OF THE CASE	2
A. Factual Background	3
B. Procedural Background	5
REASONS FOR GRANTING THE PETITION FOR WRIT OF CERTIORARI	8
A. This Court Should Provide Guidance To The Lower Courts Regarding The Proper Construction Of EMTALA So That The Statute Is Applied In A Manner That Is Consistent With Its Limited Purpose (To Assure An Adequate Response To A Medical Crisis) And That Is Compatible With The Basic Principles Of Health Care Law And With Other Federal Statutes	8
1. The Limited Purpose of EMTALA	9
2. Uncertainties as to the Scope of EMTALA	11
3. The Fourth Circuit's Misunderstanding	14

B. This Case Presents A Legal Question Of Profound Public Importance: Does Federal Law Require Physicians To Abandon Professional Judgment And To Provide Medically Inappropriate and Unethical Interventions To A Dying Patient Upon the Request Of A Parent Or Other Patient Surrogate? 15
1. The Fourth Circuit's Interpretation of EMTALA 16
2. Ambiguities in the "Plain Language" of EMTALA 16
(a) "As May be Required" 16
(b) "To Stabilize" 17
(c) The Limited Purpose of EMTALA 18
(d) The Need for a Case-By-Case Approach 18
3. As Construed by The Fourth Circuit, EMTALA Conflicts with Other Medicare Laws 20
4. As Construed by the Fourth Circuit, EMTALA Displaces the Entire Body of State Law Governing Medical Decision-Making 22
C. Certiorari Should Be Granted To Resolve A Conflict between the Fourth and Sixth Circuits: EMTALA Only Prohibits Disparate Treatment and Patient Dumping 24
1. The Conflict with the Sixth Circuit . . . 25
2. The Fourth Circuit's Weak Rationale . . 26
CONCLUSION 27

TABLE OF AUTHORITIES

CASES	PAGES
Baber v. Hospital Corp. of Am., 977 F.2d 872 (4th Cir. 1992)	*passim*
Brooker v. Desert Hosp. Corp., 947 F.2d 412 (9th Cir. 1991)	11n. 6, 26
Brooks v. Maryland Gen. Hosp. Inc., 996 F.2d 708 (4th Cir. 1993)	8, 11, 13
Burditt v. United States Dep't of Health and Human Services, 934 F.2d 1362 (5th Cir. 1991)	26
Church of the Holy Trinity v. United States, 143 U.S. 457 (1892)	18
Cleland v. Bronson Health Care Group, Inc., 917 F.2d 266 (6th Cir. 1990)	*passim*
Collins v. DePaul Hosp., 963 F.2d 303 (10th Cir. 1992)	13
Deberry v. Sherman Hosp. Ass'n, 741 F. Supp. 1302 (N.D. Ill. 1990)	12
Delaney v. Cade, 756 F. Supp. 1476 (D. Kan. 1991)	11n. 6
Evitt v. University Heights Hosp., 727 F. Supp. 495 (S.D. Ind. 1989)	11n. 5, 22
Gatewood v. Washington Healthcare Corp., 933 F.2d 1037 (D.C. Cir. 1991)	10, 11n. 6, 13
Green v. Bock Laundry Machine Co., 490 U.S. 504 (1989)	18
Johnson v. University of Chicago Hosps., 982 F.2d 230 (7th Cir. 1992)	13
Lee v. Alleghany Regional Hosp. Corp., 778 F. Supp. 900 (W.D. Va. 1991)	11n. 6

Loss v. Song, No. 89C 6952, 1990 WL 159612 (N.D. Ill. 1990) 12

Nichols v. Estabrook, 741 F. Supp. 325 (D.N.H. 1989) 11n. 5

Pennington v. Cox, 6 U.S. (2 Cranch) 33 (1804) . . 18

Power v. Arlington Hosp., 800 F. Supp. 1384 (E.D. Va. 1992) 13

Smith v. Richmond Memorial Hosp., 243 Va. 445, 416 S.E.2d 689 (1992) 12

Stevison v. Enid Health Sys., Inc., 920 F.2d 710 (10th Cir. 1990) 26

Stewart v. Myrick, 731 F. Supp. 433 (D. Kan. 1990) 11n. 5

Thornton v. Southwest Detroit Hosp., 895 F.2d 1131 (6th Cir. 1990) 12, 24, 25

STATUTES AND REGULATIONS

28 U.S.C. § 1331 . . . . . 2, 6

28 U.S.C. § 1367 . . . . . 2, 6

28 U.S.C. § 2201 2

29 U.S.C. § 794 2

42 U.S.C. § 1320a-7(b)(6) 20, 21

42 U.S.C. § 1320c-3 21

42 U.S.C. § 1320c-5 . . . . . 20, 21

42 U.S.C. § 1395 21

42 U.S.C. § 1395dd . . . . . *passim*

42 U.S.C. § 1395y(a)(1)(A) 21

42 U.S.C. § 5102 2

42 U.S.C. § 12181 2

Va. Code Ann. § 8.01-581.20 (Michie 1992) . . . 23

Va. Code Ann. § 54.1-2914(a)(9) (Michie 1991) 23

Va. Code Ann. § 54.1-2990 (Michie Supp. 1991) 22, 23, 24

MISCELLANEOUS

H.R. Rep. No. 241, 99th Cong., 2d Sess., pt. 1, at 27 (1986), *reprinted in* 1986 U.S.C.C.A.N. 42, 605 10

H.R. Rep. No. 241, 99th Cong., 2d Sess., pt. 3, at 5 (1986), *reprinted in* 1986 U.S.C.C.A.N. at 726 10

George J. Annas, *Asking the Courts to Set the Standard of Emergency Care - The Case of Baby K*, 330 New Eng. J. Med. 1542 (1994) 4n. 3

Kenneth L. Jones, M.D., *Smith's Recognizable Patterns of Human Malformation* 659-60 (4th ed. 1988) 3n. 2

No. ____

IN THE

Supreme Court of the United States

OCTOBER TERM, 1994

IN THE MATTER OF BABY K

Petition for Writ of Certiorari to the
United States Court of Appeals
For the Fourth Circuit

PETITION FOR WRIT OF CERTIORARI

The petitioners, Hospital, Mr. K, and Baby K,[1] through her guardian *ad litem*, respectfully pray that a writ of certiorari issue to review the judgment and opinion of the United States Court of Appeals for the Fourth Circuit, entered in the above-entitled proceeding on March 28, 1994.

OPINIONS BELOW

The decision of the United States Court of Appeals for the Fourth Circuit is reported at 16 F.3d 590 and is included in the Appendix at A1 to A17. The opinion of the United States District Court for the Eastern District of Virginia is reported at 832 F. Supp. 1022 and is included in the Appendix at B1 to B16. The decision of the United States Court of Appeals for the Fourth Circuit denying the Petitioners' Petition for Rehearing

[1] Pursuant to Order of the United States District Court for the Eastern District of Virginia, Alexandria Division, this case was placed under seal on January 21, 1993, and leave was granted to refer to the parties Defendant by pseudonyms. The Fourth Circuit Court of Appeals required the parties to file "sterile" pleadings, redacting information that may identify a party. This pleading has been filed in "sterile" form. The record, which is under seal, identifies the parties.

with Suggestion for Rehearing En Banc is included in the Appendix at C1 to C2.

JURISDICTION

The decision of the United States Court of Appeals for the Fourth Circuit was issued on February 10, 1994. An order, denying the petitioners' timely request for a rehearing, was issued by that court on March 28, 1994. The mandate of the United States Court of Appeals for the Fourth Circuit was issued on April 4, 1994.

The jurisdiction of this Court to issue a writ of certiorari in this case is based upon 28 U.S.C. § 1254(1). The bases for federal jurisdiction in the first instance are 28 U.S.C. §§ 1331, 1367, 2201, 42 U.S.C. §§ 1395dd, 12181, 29 U.S.C. § 794, 42 U.S.C. § 5102 (Supp. III 1985) and the pendent and ancillary jurisdiction of the federal district court.

STATUTES INVOLVED

42 U.S.C. § 1395dd (Emergency Medical Treatment and Active Labor Act abbreviated here as "EMTALA"). The full text of this statute is set forth in the Appendix at D1 to D10.

STATEMENT OF THE CASE

From the beginning, this case has posed a single overarching question: does federal law require physicians to provide to a dying patient medical interventions that serve no therapeutic or palliative purpose and that are contrary to professionally recognized standards of care? According to a divided panel of the Fourth Circuit, the answer is "yes."

If allowed to stand, the Fourth Circuit's decision in *In the Matter of Baby K* will have sweeping and unintended implications for clinical medicine. No longer will the difficult, subtle and sensitive process of clinical decision-making at the bedside of a dying patient be made in accordance with accepted medical and ethical standards. Instead, available technically feasible

care will have to be provided to a dying patient upon demand, irrespective of whether such care is medically and ethically appropriate.

The decision of the Fourth Circuit in this case transforms a law intended to protect indigent patients from being denied emergency medical services into a law requiring physicians to respond aggressively to each episode of acute deterioration in the ongoing care of a dying patient, regardless of whether such intervention is required by, or even compatible with, the established standard of medical care. This ruling has profound implications for the financing of health care in this country, for the allocation of already limited intensive care resources, for the well-being of dying patients and for the ethical integrity of the medical profession as a whole.

A. Factual Background.

Baby K was born at the Hospital on October 13, 1992. The infant was born with anencephaly, a congenital, and eventually fatal, malformation in which the cerebral cortex of the brain and a substantial portion of skull and scalp are missing. The devastating condition is described in medical textbooks as one that is incompatible with life.[2]

Lacking a functioning cerebral cortex, anencephalic infants are permanently unconscious, although they exhibit brain stem function and reflex action in varying degrees. Brain stem functions include responding to noxious stimuli (demonstrated by avoidance and crying), respiratory reflexes (breathing, coughing or hiccups), and non-interactive eye movements and facial expressions.

Baby K cannot hear, cannot see and has no cognitive abilities. She was born with a condition that deprives her of any ability to exercise cerebral functions; she has no awareness of

---

[2] *See* Kenneth L. Jones, M.D., *Smith's Recognizable Patterns of Human Malformation* 659-60 (4th ed. 1988).

and cannot interact with her environment in any way and will never be able to do so. Baby K has no ability to think, perceive or cognitively respond.

Most anencephalic infants die within days of birth.[3] There is no medical treatment to cure, correct or improve anencephaly. There is accordingly nothing Hospital physicians can do to change or help Baby K's anencephaly. The virtually universal medical standard of care for infants with anencephaly is to forego any form of aggressive medical care (including mechanical ventilation) and to provide only supportive care in the form of nutrition, hydration and warmth, permitting the tragic condition to take its natural course.

After making the prenatal diagnosis of Baby K's anencephaly, Hospital physicians discussed the nature of Baby K's condition with her mother, Ms. H. The Hospital's medical staff explained to Ms. H that Baby K's condition was permanent and that aggressive measures, including mechanical ventilation, would serve no therapeutic or palliative purpose. Ms. H rejected the physicians' advice that Baby K be given supportive care only and demanded instead that the Hospital physicians do "everything" for Baby K. "Everything" included putting Baby K on mechanical ventilation when she could not breathe on her own.

From the beginning, Baby K was unable to maintain life on her own. Hospital physicians resuscitated Baby K in the delivery room as Ms. H had demanded. From the perspective of the physicians, this gave the mother (who had undergone caesarean section) an opportunity to understand the diagnosis fully, and it gave physicians the opportunity to confirm their diagnosis. App. A2; 16 F.3d at 592.

---

[3] As of the filing of this Petition, Baby K may be the longest-lived anencephalic infant in medical history. *See* George J. Annas, *Asking the Courts to Set the Standard of Emergency Care - The Case of Baby K*, 330 New Eng. J. Med. 1542 (1994).

Following her birth, Baby K repeatedly experienced respiratory failure and was unable to maintain her own life without aggressive support by the doctors. Hospital physicians continued to advise Ms. H that mechanical ventilation served no therapeutic or palliative purpose and tried to persuade Ms. H to agree to withhold mechanical ventilation. App. A2; 16 F.3d at 592-93. Ms. H refused, continuing to demand that mechanical ventilation be provided when the infant had difficulty breathing. App. B2; 832 F. Supp. at 1025.

The father of the child, Mr. K, to whom the mother is not married, did not want Baby K to undergo mechanical ventilation or other aggressive measures. From the outset, Mr. K has agreed with the physicians' position that Baby K should receive only supportive care. App. B4; 832 F. Supp. at 1026.

No physician-parental consensus was achieved. The Hospital attempted to transfer the infant to another hospital willing to provide the interventions the mother sought. Indicative of the accepted standard of care for anencephaly, no hospital or physician was willing to provide the treatments the mother demanded.

When she is not in respiratory distress, Baby K remains in a nursing home in Northern Virginia. Since her first discharge from the Hospital in November 1992, Baby K has been brought back to the Hospital in respiratory failure four times. On each occasion, the Hospital and its physicians have provided the aggressive care Ms. H has demanded to maintain the *status quo* during the pendency of this matter.

B. Procedural Background.

Shortly after Baby K's second admission to the Hospital on January 15, 1993, the Hospital filed this proceeding for declaratory relief to resolve the issue of what level of care it is obligated to render to Baby K. Specifically, the Hospital sought declaratory relief that it is not obligated to render medically and

ethically inappropriate medical treatment to Baby K under EMTALA, Section 504 of the Rehabilitation Act of 1973 ("Rehabilitation Act"), the Americans With Disabilities Act ("ADA"), the Child Abuse Amendments of 1984, or Virginia state or common law. The jurisdiction of the District Court was based on 28 U.S.C. §§ 1331, 1367.

After suit was filed, the District Court appointed a guardian *ad litem* to represent the interests of the infant. Following his assessment, the guardian *ad litem* concluded that it was in the best interest of Baby K to receive supportive care but that the Hospital should not be compelled to provide invasive procedures or aggressive medical care, including mechanical ventilation.

The District Court conducted a two-day trial in May 1993. At trial, the Hospital relied upon the testimony of three physicians and one ethicist, each of whom testified that the standard of medical care in the United States for anencephalic infants is to provide only supportive care in the form of nutrition, hydration and warmth and not to provide mechanical ventilation or other treatments that do not help, cure, correct or alleviate the anencephaly. The father testified that he agreed with this course of care.

Following trial, the District Court issued an opinion on July 1, 1993, denying the relief requested by the Hospital. The District Court ruled that the Hospital has a duty under EMTALA to render even futile medical treatment if requested to do so by a parent.

The District Court also ruled that the Rehabilitation Act and the ADA require physicians to provide the same treatment to Baby K that physicians would provide to a patient with a different condition, and that failure to do so would constitute discrimination on the basis of a handicap. In reaching this conclusion, the District Court ignored decisions by the Courts of Appeals for the Second and Tenth Circuits holding that

medical treatment decisions properly relate to the condition being treated and that a *bona fide* medical judgment cannot constitute a violation of Section 504 of the Rehabilitation Act. Finally, the District Court declined to exercise jurisdiction on the counts involving the Child Abuse Amendments and state law. The Hospital, Mr. K and the guardian *ad litem* appealed to the Fourth Circuit Court of Appeals.

The Fourth Circuit affirmed the District Court's decision as to EMTALA by a 2-1 majority, with Senior Circuit Judge Sprouse dissenting. The panel majority held that Baby K's breathing difficulty constitutes an emergency medical condition; that diagnosis of this condition triggers the duty of the Hospital to provide Baby K with stabilizing treatment; and that, therefore, EMTALA obligates the Hospital to provide respiratory support to Baby K when she is brought to the Hospital in respiratory distress. App. A6-A7; 16 F.3d at 594-95.[4] Under the Fourth Circuit's analysis, the facts that Baby K has anencephaly, and that the requested treatment is medically and ethically inappropriate and is outside the standard of care in the treatment of anencephalic infants, had no bearing on the interpretation of EMTALA.

Judge Sprouse, in dissent, agreed with the Hospital's contention that Baby K's anencephaly, not the subsidiary respiratory failure, is the "condition" that is pertinent to the applicability of EMTALA. He concluded that EMTALA "was not intended to cover the continued emergencies that typically attend patients like Baby K" and, therefore, would have ruled that "this case [is] outside the scope of EMTALA's anti-dumping provisions." App. A15; 16 F.3d at 598.

---

[4] The panel majority concluded that because "the Hospital has a duty to render stabilizing treatment under EMTALA, [the Court] need not address its obligations under the remaining federal statutes or the laws of Virginia." App. A1 n.2; 16 F.3d at 592 n.2.

The panel voted 2-1 to deny the petition for rehearing submitted by the Hospital, Mr. K and Baby K. After a member of the Court requested a poll on the Hospital's suggestion for rehearing *in banc*, a majority of the judges voted to deny rehearing *in banc* by a vote of 9-4. As a result of the Court's decision, the Hospital is now legally obligated to provide mechanical ventilation to Baby K as well as any other aggressive measure necessary to achieve "stability" when she is brought back to the Hospital with "[a]ny diagnosed 'emergency medical condition'. . . ." App. A7 n.7; 16 F.3d at 595 n.7.

REASONS FOR GRANTING THE PETITION FOR WRIT OF CERTIORARI

A. This Court Should Provide Guidance To The Lower Courts Regarding The Proper Construction Of EMTALA So That The Statute Is Applied In A Manner That Is Consistent With Its Limited Purpose (To Assure An Adequate Response To A Medical Crisis) And That Is Compatible With The Basic Principles Of Health Care Law And With Other Federal Statutes.

The Emergency Medical Treatment and Active Labor Act was enacted in 1986 to respond to Congress' "'concern that hospitals were 'dumping' patients [who were] unable to pay, by either refusing to provide the emergency medical treatment or transferring patients before their emergency conditions were stabilized.'" App. A3; 16 F.3d at 593, quoting *Brooks v. Maryland Gen. Hosp. Inc.*, 996 F.2d 708, 709 (4th Cir. 1993). Unfortunately, an imperfect alignment between the language and purpose of the statute has led the lower courts to extend EMTALA's reach well beyond the documented Congressional aim of guaranteeing limited access to emergency medical attention to, in this case, a law authorizing patients or their surrogates to dictate medical treatments that are contrary to accepted standards of medical care.

In the eight years since its enactment, lower courts have extended EMTALA's reach to all patients, regardless of indigence, and from emergency rooms to ongoing hospital care. A limited federal duty, which was not intended to displace state malpractice laws, has gradually become an alternative to a malpractice action for any claim involving alleged deficiencies in hospital care of patients in crisis.

The misunderstanding has reached absurd proportions in this case: EMTALA has been interpreted to constrain medical choices in the ongoing care of a dying infant born in the Hospital. Even more astoundingly, the statute has been read to require physicians to violate accepted medical standards and to displace the principles undergirding the federally funded Medicare and Medicaid programs as well as state laws that have traditionally governed the practice of medicine.

Already pervasive uncertainty about the reach of EMTALA has been magnified by the Fourth Circuit's decision in this case, which can be expected to spawn substantial litigation as courts struggle to define the limits of an expanding federal "duty to treat." This Court must now take matters in hand to realign the obligations imposed by EMTALA with its limited purpose.

1. The Limited Purpose of EMTALA.

Congress enacted EMTALA to address its concern with the practice of patient dumping. *See Baber v. Hospital Corp. of Am.*, 977 F.2d 872, 880 (4th Cir. 1992). The Congress was concerned about:

> the increasing number of reports that hospital emergency rooms are refusing to accept or treat patients with emergency conditions if the patient does not have medical insurance. The Committee is most concerned that medically unstable patients are not being treated appropriately. There have been reports of situations

> where treatment was simply not provided. In numerous other instances, patients in an unstable condition have been transferred improperly, sometimes without the consent of the receiving hospital. . . . The Committee wants to provide a strong assurance that pressures for greater hospital efficiency are not to be construed as license to ignore traditional community responsibilities and loosen historic standards.

H.R. Rep. No. 241, 99th Cong., 2d Sess., pt. 1, at 27 (1986), *reprinted in* 1986 U.S.C.C.A.N. 42, 605. The concern addressed was the "provision of adequate emergency room medical services to individuals who seek care, particularly as to the indigent and uninsured. . . ." H.R. Rep. No. 241, 99th Cong., 2d Sess., pt. 3, at 5 (1986), *reprinted in* 1986 U.S.C.C.A.N. at 726.

The avowed purpose was "not to guarantee that all patients are properly diagnosed, or even to ensure that they receive adequate care, but instead to provide an 'adequate first response to a medical crisis' . . . ." *Baber v. Hospital Corp. of Am.*, 977 F.2d at 880.

In light of the limited purpose of EMTALA, it is clear that Congress did not intend to extend, displace, or duplicate the corpus of state law relating to malpractice liability or medical decision-making. Liability for alleged short-comings in diagnosis or treatment in the course of an emergency is still determined primarily by state law. *See Baber v. Hospital Corp. of Am.*, 977 F.2d at 880; *Gatewood v. Washington Healthcare Corp.*, 933 F.2d 1037, 1041 (D.C. Cir. 1991). In fact, Congress was careful to state that EMTALA was not intended to preempt state law. 42 U.S.C. § 1395dd(f). It is similarly clear that Congress did not intend for EMTALA to displace or modify the prevailing standards of medical care. EMTALA did not create a national standard of care. Quite to the contrary, the Act accepts that standard of care that is applied generally at the Hospital.

See Brooks v. Maryland General Hosp., 996 F.2d at 713. At its core, EMTALA is designed to prevent disparate treatment. *Id.*

2. Uncertainties as to the Scope of EMTALA.

Since its enactment, the lower courts have been confused as to the scope of EMTALA. First came the confusion as to whether EMTALA applied to poor people or to all people. Some courts found that based upon the legislative history of EMTALA, EMTALA applied only to indigent patients or those without health insurance.[5] Other courts, however, found that the patient's economic status was irrelevant. The issue appears to have been resolved in favor of extending protection to all patients - a conclusion compatible with the language of the statute and the overall purpose of providing an appropriate first response in a medical emergency.[6]

Courts have also been uncertain as to whether EMTALA obligations are limited to a patient who initially arrives at an emergency room (and who is transferred without being stabi-

[5] *See Stewart v. Myrick*, 731 F. Supp. 433 (D. Kan. 1990) (EMTALA designed to protect those who are denied medical care for economic reasons); *Nichols v. Estabrook*, 741 F. Supp. 325 (D.N.H. 1989) (plaintiffs did not state a claim because plaintiffs did not allege that their financial condition or lack of health insurance contributed to the failure to treat); *Evitt v. University Heights Hosp.*, 727 F. Supp. 495 (S.D. Ind. 1989) (no cause of action where patient was not indigent or uninsured).

[6] *See Brooker v. Desert Hosp. Corp.*, 947 F.2d 412 (9th Cir. 1991) (EMTALA applies to any and all patients, not just patients with insufficient resources); *Gatewood v. Washington Healthcare Corp.*, 933 F.2d at 1040 (EMTALA applies regardless of economic motive); *Cleland v. Bronson Health Care Group, Inc.*, 917 F.2d 266 (6th Cir. 1990) (explicit language applies to any and all patients, not just the indigent and uninsured); *Delaney v. Cade*, 756 F. Supp. 1476 (D. Kan. 1991) (EMTALA claims not limited to denial of treatment based upon inability to pay), *rev'd in part on other grounds*, 986 F.2d 387 (10th Cir. 1993), *and rev'd on other grounds*, 1994 U.S. App. LEXIS 13290 (10th Cir. 1994); *Lee v. Alleghany Regional Hosp. Corp.*, 778 F. Supp. 900 (W.D. Va. 1991) (can state EMTALA claim without alleging denial of treatment based upon inability to pay).

lized), or whether the statute also applies to a situation in which a patient already in the hospital has an emergency medical condition or goes into active labor. *Compare Loss v. Song*, No. 89C 6952, 1990 WL 159612 (N.D. Ill. 1990) (plaintiff normally must plead presentation to the emergency room) *and Deberry v. Sherman Hosp. Ass'n*, 741 F. Supp. 1302 (N.D. Ill. 1990) (patient must allege that he went to the emergency room), *summ. judgment granted, dismissed*, 769 F.Supp. 1030 (N.D. Ill. 1991) *with Thornton v. Southwest Detroit Hosp.*, 895 F.2d 1131 (6th Cir. 1990) (EMTALA intended to ensure that patients with medical emergencies receive emergency care which does not stop when a patient is wheeled from the emergency room into the main hospital) *and Smith v. Richmond Memorial Hosp.*, 243 Va. 445, 416 S.E.2d 689 (1992) (EMTALA applies to situation in which a patient already in the hospital has an emergency medical condition or is in active labor), *cert. denied*, 113 S.Ct. 442 (1992).

The nature of the confusion is evident in the Seventh Circuit's recent decisions in *Johnson v. University of Chicago Hospitals*. In that case the Seventh Circuit first reversed a district court ruling and found potential EMTALA liability where a telemetry operator in the University of Chicago Hospitals-operated telemetry system gave instructions to paramedics to take an infant in full cardiac arrest to another hospital because the University of Chicago Hospitals had no further capacity in its pediatric intensive care unit. 1992 U.S. App. LEXIS 25096 (7th Cir. Oct. 7, 1992).

At that time, the Seventh Circuit found that the language in 42 U.S.C. § 1395dd requiring a hospital to provide appropriate medical screening to an individual who "[came] to the [hospital's] emergency department" encompassed an individual who seeks "medical assistance from a hospital through telemetry communications and paramedic services without coming to the hospital's emergency room." *Id.* at *11.

Two months later, the Seventh Circuit withdrew its opinion and vacated the judgment *sua sponte*. The Seventh Circuit observed then that the infant never came to the hospital and that a hospital-operated telemetry system is distinct from the same hospital's emergency room. The Court concluded finally that "[n]othing in the language of the statute or in the legislative history . . . suggests an extension of [EMTALA] to create a duty in a telemetry operator that would be actionable. . . ." *Johnson v. University of Chicago Hosps.*, 982 F.2d 230, 233 (7th Cir. 1992).

Confusion as to the level of care EMTALA obligates hospitals to provide is found in cases that struggle to define the limits of the EMTALA duty to treat. The lower courts have generally conceded that EMTALA was not intended to supplant medical malpractice remedies. *See Collins v. DePaul Hosp.*, 963 F.2d 303, 307 (10th Cir. 1992); *Gatewood v. Washington Healthcare Corp.*, 933 F.2d at 1037. Under this line of decisions, the level of care a hospital must provide is that standard to which it generally adheres. *See Brooks v. Maryland Gen. Hosp.*, 996 F.2d at 731; *Cleland v. Bronson Health Care Group, Inc.*, 917 F.2d 266, 271 (6th Cir. 1990). However, other courts have ruled that a violation of EMTALA can be proven by demonstrating that the hospital failed to meet the applicable standard of care, which may be the malpractice standard of care. *See Power v. Arlington Hosp.*, 800 F. Supp. 1384 (E.D. Va. 1992). It is in the latter cases that the line between malpractice actions and an EMTALA violation "blurs somewhat." *Id.* at 1837 n.6. In the Baby K case, the Fourth Circuit found the required level of care under EMTALA to be something different than the treatment that would be uniformly provided to other anencephalic infants or treatment that meets the standard of care. Instead the Fourth Circuit construed EMTALA to require a level of care that was outside the prevailing standard of care. App. A10-A11; 16 F.3d at 596.

3. The Fourth Circuit's Misunderstanding.

As will be shown below, the Fourth Circuit's decision in this case takes several additional steps in the erroneous expansion of EMTALA. First, it applies the statute in a context of continuing care in which the Hospital has not transferred — and has no ability or intention to transfer — a patient in an unstable condition as proscribed by EMTALA. In so doing, the Fourth Circuit's decision is in conflict with rulings by the Sixth Circuit. (This issue is discussed below in Part C, *infra*.)

Second, the Fourth Circuit's decision profoundly misconstrues the term "emergency medical condition" to cover any episode of acute deterioration even if the episode is symptomatic of, and an expected consequence of, an underlying fatal condition and even if the patient is in the process of dying. This erroneous interpretation is unprecedented and, if allowed to stand, will magnify the confusion regarding the impact of EMTALA on the care of dying patients.

Third, the Fourth Circuit's decision holds that the prevailing professional standard of care has no bearing on the scope of obligations imposed by EMTALA. This conclusion is breathtaking in both its implications and its defiance of traditional canons of statutory construction. In reaching this conclusion, the Fourth Circuit took no account of its obligations to harmonize the construction of EMTALA with other features of federal health care law, particularly those provisions of the Medicare statutes requiring providers to conform to the prevailing standard of care.

The Fourth Circuit's decision in this case epitomizes and magnifies the confusion and error that now prevail in the lower courts regarding the meaning of EMTALA. If allowed to stand, it will cause untold mischief. It is time for this Court to step in and clarify the limited purpose of EMTALA and the restricted scope of the obligations it imposes.

B. This Case Presents A Legal Question Of Profound Public Importance: Does Federal Law Require Physicians To Abandon Professional Judgment And To Provide Medically Inappropriate and Unethical Interventions To A Dying Patient Upon the Request Of A Parent Or Other Patient Surrogate?

The Fourth Circuit acknowledged the Hospital's contention that aggressive treatment for Baby K, including mechanical ventilation, would exceed the prevailing standard of medical care. App. A11; 16 F.3d at 596-97. It also recognized "the dilemma facing physicians who are requested to provide treatment they consider morally and ethically inappropriate." App. A11; 16 F.3d at 596. The Court nonetheless held that EMTALA obligates the Hospital and its physicians to continue to provide whatever treatment is available to "stabilize" any of the inevitable forms of deterioration that Baby K or any other dying patient may suffer. App. A13; 16 F.3d at 597.

As a consequence of the Fourth Circuit's ruling in this case, complex medical decisions need not be made in accordance with accepted medical and ethical standards. Instead, whenever a family member of a dying patient wants "everything to be done" and "not to stop," it will have to be done as a matter of federal law.

The panel majority ruled that this disturbing result was dictated by the "plain language" of EMTALA. App. A11; 16 F.3d at 596. However, the pertinent provisions of EMTALA are amenable to an alternative construction that is linguistically sensible, consistent with clearly articulated Congressional purposes and compatible with generally accepted standards of medical care. "Plain language" is an axiom of statutory construction. In this case, the axiom of construction has been used as a mechanism for destruction, eviscerating established principles of federal health care law.

1. The Fourth Circuit's Interpretation of EMTALA.

The Fourth Circuit construes subsection (b) of EMTALA, 42 U.S.C. § 1395dd(b), to require physicians to provide, upon demand of the mother, mechanical ventilation or any other "stabilizing treatment" to Baby K when she experiences respiratory failure or any other "emergency medical conditions" as a consequence of her anencephaly. App. A7 n.7; 16 F.3d at 594-95 n.7. The Fourth Circuit has concluded that the "plain language" of EMTALA requires a hospital to provide that treatment necessary to prevent the material deterioration of each discrete emergency medical condition suffered by a dying patient, irrespective of whether the patient is "transferred" or "dumped" by the Hospital. App. A13-A14; 16 F.3d at 598. The Fourth Circuit expressly did not limit the Hospital's duty under EMTALA to respiratory support for episodes of respiratory failure.

2. Ambiguities in the "Plain Language" of EMTALA.

The language of EMTALA is in fact susceptible to a variety of alternative constructions that would not obligate the Hospital to administer inappropriate treatments to Baby K and that are compatible with Congress' limited legislative purpose of providing an appropriate first response in a medical crisis. *See Baber v. Hospital Corp. of Am.*, 977 F.2d at 880.

(a) "As May be Required."

EMTALA provides in pertinent part that: "If . . . the hospital determines that the individual has an emergency medical condition, the hospital must provide . . . such treatment *as may be required* to stabilize the medical condition." 42 U.S.C. § 1395dd(b) (emphasis added). The use of the phrase "as may be required" may be understood to anchor the duty to "stabilize the [patient's] medical condition" to professional standards.

Professionally recognized standards of medical care do *not* "require" that physicians provide aggressive measures such as mechanical ventilation to an anencephalic infant. Absent a medical standard "requiring" treatment for a patient with anencephaly, EMTALA can be read literally so as not to obligate physicians to provide mechanical ventilation to Baby K or to provide any other medically inappropriate interventions.

This construction of section (b) is consistent with prevailing medical principles as well as with Congress' ultimate objective that "appropriate treatment" be given "to stabilize patients who have emergency medical conditions." H.R. Rep. No. 241, 99th Cong., 1st Sess., pt. 1, at 4 (1985), *reprinted in* 1986 U.S.C.C.A.N. at 582; 131 Cong. Rec. H9495 (daily ed. Oct. 31, 1985) (Statement of Rep. Rostenkowski). As the Sixth Circuit in *Cleland v. Bronson Health Care Group, Inc.*, recognized: "Who, after all, can be found to stand up for 'inappropriate' treatment or actions of any sort . . . . The same reasoning [that applies to the medical screening requirement] applies to stabilization, though with even greater force." *Cleland v. Bronson Health Care Group, Inc.*, 917 F.2d at 271.

(b) "To Stabilize."

The definition of the term "to stabilize" in subsection (b) of EMTALA is to "provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur *during the transfer of the individual from a facility ....*" *See* 42 U.S.C. § 1395dd(d)(3)(A) (Supp. 1993) (emphasis added). The statutory definition of the term ties the duty to stabilize to: (i) a transfer of a patient from one hospital to another facility, or (ii) a discharge or transfer from a hospital while a patient is in unstable condition. Thus, absent the discharge or transfer of a patient in unstable condition (a "dump"), EMTALA is not triggered. This principle has been enunciated by the Sixth Circuit. *See* Section C, *infra*.

In sum, the language of EMTALA is ambiguous in relation to the circumstances presented in this case and is susceptible to a variety of constructions other than the one adopted by the Fourth Circuit. The ambiguity can be sensibly resolved only by considering Congressional purpose. *See, e.g., Green v. Bock Laundry Machine Co.*, 490 U.S. 504 (1989); *Church of the Holy Trinity v. United States*, 143 U.S. 457 (1892); *Pennington v. Cox*, 6 U.S. (2 Cranch) 33 (1804).

(c) The Limited Purpose of EMTALA.

There is no indication in the legislative history of EMTALA that Congress meant to extend the statute's reach to hospital-patient relationships that do not involve "dumping." EMTALA's general principle is to avoid death or irreparable impairment before a condition has been properly evaluated and the patient turned away from a hospital in unstable condition. As Judge Sprouse noted in his dissent, there is no suggestion of patient "dumping" in the Baby K case. App. A15; 16 F.3d at 598.

It follows that if a patient's condition is fully known and a medically appropriate treatment plan is implemented at the Hospital, any EMTALA obligation is satisfied. In the case of dying patients, the treatment plan would include decisions as to how to respond to end-of-life situations. Such treatment decisions would, however, be based upon clinical assessment and governed under state negligence or medical malpractice standards, not EMTALA. *See Baber v. Hospital Corp. of Am.*, 977 F.2d at 880.

(d) The Need for a Case-By-Case Approach.

Judge Sprouse, in his dissent, observed that the case of Baby K exemplifies the need to take a case-by-case approach to determine if an emergency episode is governed by EMTALA. Judge Sprouse concluded that in Baby K's case, her unspeakably

tragic illness should be regarded as a continuum, not as a series of discrete emergency medical conditions to be considered in isolation. App. A16; 16 F.3d at 599 (Sprouse, J., dissenting).

In rejecting such a case-by-case approach, the Fourth Circuit observed that

> EMTALA does not carve out an exception for anencephalic infants in respiratory distress any more than it carves out an exception for comatose patients, those with lung cancer, or those with muscular dystrophy — all of whom may repeatedly seek emergency stabilizing treatment for respiratory distress and also possess an underlying medical condition that severely affects their quality of life and ultimately may result in their death.

App. A14; 16 F.3d at 598. Here, the Fourth Circuit raises the specter that were it to rule in favor of the Hospital, the door would be open for hospitals and physicians to deny care for patients with serious diseases, such as cancer, AIDS or other serious illnesses on the grounds that care would be futile. *Id.*

In essence, the Fourth Circuit suggests that physicians and hospitals may use EMTALA to escape their professional obligations. *Id.* There are no facts in evidence, however, to suggest that there was an effort to avoid professional responsibilities for Baby K.

It is solely because of her anencephaly that Baby K cannot benefit from medical treatment and that physicians do not wish to provide aggressive treatment. A patient with another medical condition such as AIDS or cancer or muscular dystrophy may well benefit from mechanical ventilation, and it would be medically appropriate to provide it. Only by permitting physicians and hospitals to exercise proper medical judgment can one harmonize the statutory intent to ensure "an appropriate first response," with the language of EMTALA and a professional

obligation to provide only medically and ethically appropriate care.

3. As Construed by The Fourth Circuit, EMTALA Conflicts with Other Medicare Laws.

The Fourth Circuit's failure to align the text of EMTALA with its underlying purpose leads it to construe the statute in a manner that is incompatible with fundamental principles governing the Medicare and Medicaid programs. The Fourth Circuit's *Baby K* decision puts EMTALA, one part of the Medicare law, in conflict with another part of that law, 42 U.S.C. § 1320c-5, which prescribes the standard of care hospitals and physicians are to follow in the Medicare program.

In this case, the Fourth Circuit has construed subsection (b)(1)(A) of EMTALA to require a hospital and physician to provide medical treatment to a patient that is outside the prevailing standards of care and that the physician reasonably considers to be medically and ethically inappropriate. In abiding by the court's ruling, however, hospitals and physicians will violate their statutory obligation under 42 U.S.C. § 1320c-5 and other Medicare statutes to provide only such care as is medically necessary and consistent with prevailing standards of medical care. *Compare* 42 U.S.C. §§ 1320c-5 and 1320a-7(b)(6) *with* 42 U.S.C. § 1395dd(d)(3).

Congress specifically incorporated Medicare standards of medical practice into the implementation and enforcement of EMTALA. Section (d)(3) of EMTALA provides that the appropriate Medicare peer review organization, acting in accordance with Title XI of the Social Security Act, 42 U.S.C. § 1320c-1 to -13 shall determine whether a violation of EMTALA has occurred with respect to any individual for purposes of imposing certain sanctions. *See* 42 U.S.C. § 1395dd(d)(3). In making its determination, the Medicare peer review organization is guided by

the principles governing the provision of medical care in the Medicare programs. *See* 42 U.S.C. § 1320c-3.

Reading subsection (b)(1)(A) of EMTALA *in pari materia* with the rest of EMTALA reinforces the proposition that the stabilizing requirement imposed by subsection (b)(1)(A) must be anchored in prevailing standards of medical practice. Subsection (a) of EMTALA requires hospitals to "provide for an *appropriate* medical screening examination." 42 U.S.C. § 1395dd(a) (emphasis added). The term "appropriate" clearly ties EMTALA'S screening requirement to the prevailing standard of care.

In addition, subsection (c) of EMTALA, which prescribes the conditions under which a hospital is authorized to transfer a patient, defines an "appropriate transfer" as one in which the receiving facility "has agreed to accept transfer of the individual and to provide *appropriate medical treatment.*" 42 U.S.C. § 1395dd(c) (emphasis added). Under subsection (c) a hospital can relieve itself of its EMTALA obligation by arranging for transfer to another facility that has agreed to provide "medically appropriate care." *Id.* The details of the patient's care are left to professional standards and state malpractice law.

It is clear from the overall design of EMTALA and its place in the Medicare law, that Congress intended for EMTALA's stabilizing requirement to be grounded in accepted professional standards, consistent with the rest of the Medicare law, specifically 42 U.S.C. § 1320c-5 (which requires the provision of care that meets professionally recognized standards); 42 U.S.C. §1395y(a)(1)(A) (no payment is to be made for medical services that are not reasonable and necessary); 42 U.S.C. § 1320a-7(b)(6) (providing for exclusion from the Medicare and Medicaid program as punishment for providing services to patients that are medically unnecessary or fail to meet professionally recognized standards of care); and 42 U.S.C. § 1395 (the Medicare law shall

not be construed to exercise any supervision or control over the practice of medicine).

4. As Construed by the Fourth Circuit, EMTALA Displaces the Entire Body of State Law Governing Medical Decision-Making.

As set forth above, EMTALA has been susceptible to a variety of expansive interpretations, many incongruent with its limited purpose. Unless this Court brings the construction of EMTALA into alignment with its purpose, its continuing expansion is likely to preempt state tort law and federalize emergency medical care, as well as the care of dying patients.

With respect to preemption, EMTALA states that "the provisions of this section do not preempt any state or local law requirement, except to the extent that the requirement directly conflicts with a requirement of this section." 42 U.S.C. § 1395dd(f).

When, however, does a state law "directly conflict" with EMTALA? In *Evitt v. University Heights Hosp.*, 727 F. Supp. 495, 497 (S.D. Ind. 1989), the district court found that EMTALA contained no explicit language aimed toward federal preemption of general medical malpractice law. Rather, the federal statute was specifically directed to the problem of patient dumping.

In the case of Baby K, however, the Fourth Circuit found that EMTALA preempted state law even in the absence of EMTALA language that directly conflicted with a state statute. Under Virginia law, a physician cannot be required to provide care that the physician determines to be medically or ethically inappropriate. Section 54.1-2990 of the Code of Virginia provides in pertinent part that "[The Health Care Decisions Act shall not] be construed to require a physician to prescribe or render medical treatment to a patient that the physician determines to be medically or ethically inappropriate." *See* Va. Code

Ann. § 54.1-2990 (Michie Supp. 1991). Simply put, under Virginia law a patient's right to make treatment decisions is not absolute. Rather, a patient's right to make medical decisions is limited by the physician's professional obligation to exercise reasonable clinical judgments. Virginia law explicitly recognizes that a physician retains the prerogative to decline to provide medical care that the physician reasonably deems to be medically or ethically wrong.

Indeed, were a physician to acquiesce to patient demands for medically inappropriate treatments, the physician would be in violation of Virginia law. The practice of medicine is defined in Virginia as the "prevention, diagnosis and treatment of human physical or mental ailments, conditions, diseases, pain or infirmities by any means or method." Va. Code Ann. § 54.1-2900 (Michie 1991). Physicians are required to act in a manner that is consistent with the "standards of ethics of [their] branch of the healing arts." Va. Code Ann. § 54.1-2914(a)(9) (Michie 1991). Physicians are held to such standards of medical care as could be exercised by a reasonably prudent practitioner in the same field or practice or specialty in the Commonwealth. Va. Code Ann. § 8.01-581.20 (Michie 1992).

Notwithstanding these long-standing and generally accepted principles of state medical regulation, the Fourth Circuit in the case of Baby K found that the language of EMTALA preempted Virginia Code § 54.1-2990. The Fourth Circuit reasoned that: (i) EMTALA does not provide an explicit exception for stabilizing treatments that physicians deem medically or ethically inappropriate; and (ii) that state law must give way to federal legislation where a valid act of Congress, fairly interpreted, is in actual conflict with the law of the state. App. A12, 16 F.3d at 597. The Court ruled that because the Hospital did not allege that EMTALA was an invalid act of Congress, EMTALA preempted Virginia Code § 54.1-2990. *Id.* As a result of its wooden construction of EMTALA, the Fourth

Circuit held that the statute preempted Virginia Code § 54.1-2990 even though EMTALA does not contain language that "directly" conflicts with it.

C. Certiorari Should Be Granted To Resolve A Conflict Between the Fourth and Sixth Circuits: EMTALA Only Prohibits Disparate Treatment and Patient Dumping.

The Fourth Circuit's ruling conflicts in principle with decisions of the Sixth Circuit. The Sixth Circuit has held that EMTALA is violated only when there has been an improper transfer of a patient in unstable condition, i.e., a "dump." *See Cleland v. Bronson Health Care Group, Inc.*, 917 F.2d at 271; *Thornton v. Southwest Detroit Hosp.*, 895 F.2d at 1131.

In contrast, the Fourth Circuit infers from EMTALA a duty to prevent deterioration of a patient with an emergency medical condition unless the patient is transferred elsewhere in accordance with EMTALA. In other words, the obligation is to stabilize regardless of whether there is a "dump." *See* App. A13; 16 F.3d at 597. The Court reasoned that Congress did not intend to allow hospitals and physicians "to avoid liability under EMTALA by accepting and screening a patient and then refusing to treat the patient because the patient cannot or will not be transferred." *See* App. A13; 16 F.3d at 598.

There is no basis in the record for questioning whether the Hospital would treat Baby K. The question was whether EMTALA permitted the physicians to provide only medically appropriate treatment, i.e., nutrition, hydration, and warmth, or whether they must also provide the "treatment," including mechanical ventilation, requested by the mother.

The Fourth Circuit has acknowledged in other cases that questions as to what is the proper treatment are questions "best resolved" under existing and developing state negligence and medical malpractice theories of recovery - not under EMTALA.

Baber v. Hospital Corp. of Am., 977 F.2d at 880. In this case, however, the Fourth Circuit determined that, under the "plain language" of EMTALA, mechanical ventilation was the required treatment for respiratory failure caused by anencephaly.

This conflict in principle between the Courts of Appeals pits a uniform obligation to provide life-sustaining interventions, irrespective of a patient's clinical condition, against broadly accepted professional standards of medical care.

1. The Conflict with the Sixth Circuit.

The Sixth Circuit has construed EMTALA narrowly so as to permit correction of the specific abuses for which the statute was designed: hospital "dumping" of patients. The Sixth Circuit expressly acknowledges that an improper transfer — a "dump" — is required to trigger a cause of action under EMTALA. According to the Sixth Circuit, a party bringing an action under EMTALA "must show that she was suffering from an 'emergency medical condition' *and* that the defendant [hospital] transferred [the plaintiff] before it had 'stabilized' her within the meaning of the Act." *Thornton v. Southwest Detroit Hosp.*, 895 F.2d at 1133 (emphasis added). As the Sixth Circuit further noted in *Cleland v. Bronson Health Care Group, Inc.*, Congress "did limit the cause of action" provided by EMTALA "to only those who did not receive an 'appropriate' screening *or who were not 'stabilized' before being transferred or discharged.*" 917 F.2d at 271 (emphasis added).

The Fourth Circuit apparently felt constrained to reach the opposite result by reason of the "plain language" of EMTALA. *See* App. A10; 16 F.3d at 596. As discussed at length above, however, the language of the statute is susceptible to a variety of alternative constructions. Only the construction of the Sixth Circuit is compatible with Congress' limited legislative purpose of providing an appropriate first response in a medical crisis. *See Baber v. Hospital Corp. of Am.*, 977 F.2d at 880.

Except for the Baby K case, EMTALA cases in all other Circuits involve an alleged transfer of a patient in unstable condition. *See, e.g., Brooker v. Desert Hosp. Corp.*, 947 F.2d 412 (9th Cir. 1991) (EMTALA required hospital to refrain from transferring patient unless she was in stable condition); *Burditt v. United States Dep't of Health and Human Services*, 934 F.2d 1362 (5th Cir. 1991) (physician improperly transferred patient with hypertension who was in active labor); *Stevison v. Enid Health Sys. Inc.*, 920 F.2d 710 (10th Cir. 1990) (patient left hospital without proper screening; if treatment were required, hospital must stabilize the condition before transfer).

2. The Fourth Circuit's Weak Rationale.

In rejecting the Hospital's plain language interpretation of EMTALA, the Fourth Circuit reasons that the limited reading of the statute would allow hospitals and physicians to "avoid providing stabilizing treatment by simply refusing to transfer the patient or, as in the case of Baby K, elect not to provide stabilizing treatment because other hospitals will not accept a transfer." App. A13; 16 F.3d at 597. The fundamental problem with the Court's reasoning is that its expanded reading of the statute is designed to solve an altogether imaginary problem. First, as the Fourth Circuit itself concedes, the Baby K case does not involve a refusal to transfer Baby K. On the contrary, no hospital or physician would accept Baby K as a transfer. *See* App. A3; 16 F.3d at 593.

Secondly, the Baby K case does not involve a situation of "electing" not to provide stabilizing treatment. There is no stabilizing treatment for Baby K because there is no stabilizing treatment for anencephaly. Baby K's clinical condition is beyond treatment; her discrete episodes of respiratory failure are integral to and symptomatic of her anencephaly. Thus, Hospital doctors were not "electing" to forego available treatments; the doctors were recognizing the limits of the treatment available

and intentionally selecting care appropriate for the infant's overall medical condition.

To the extent there are issues as to the refusal or inadequacy of treatment of a patient in the absence of a transfer, these are issues the Fourth Circuit has recognized to be the province of state malpractice law. *See Brooks v. Maryland Gen. Hosp.*, 996 F.2d at 708.

The Baby K case is simply not the case intimated by the Fourth Circuit: a case where refusal to stabilize is a sham to avoid a medically appropriate first response. Instead, the Hospital's inability to stabilize reflects the prevailing standard of medical care, a standard the Fourth Circuit incorrectly reads out of subsection (b) of EMTALA altogether.

It is highly unlikely that a hospital or its physicians would endanger patients by admitting a patient and then intentionally failing to provide an appropriate emergency response, thereby providing substandard care, and subjecting themselves to malpractice liability. The Fourth Circuit, however, construes EMTALA to protect against this remote possibility. In so doing, the Fourth Circuit extends the reach of the statute in conflict with both the facts of the case and the elements of liability established by the Sixth Circuit.

CONCLUSION

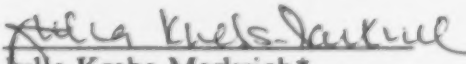
In the case of Baby K, the Fourth Circuit has effectively ruled that the professional standard of care is irrelevant to emergency medical treatment decisions as a matter of federal law. Moreover, because of its befuddling and expansive reading of "emergency medical condition" to cover the symptomatic deterioration of dying patients, the Fourth Circuit has displaced the subtle clinical decisions at the bedsides of dying patients with a wooden and inflexible obligation under federal law. According to the Fourth Circuit, the only relevant questions are (i) whether a parent or other patient surrogate wants a treatment;

and (ii) whether a physician can technically provide the treatment to permit the patient to persist in his/her condition. This ruling is based on profound misinterpretations of federal law and would have profound implications for the care of patients that Congress could not possibly have intended.

In the end one must recognize and accept the limits of medical science. Medicine cannot perform the miracles the mother of Baby K seeks. Medicine cannot cure, correct or improve anencephaly, and this Court should not sustain the Fourth Circuit's decision that compels hospitals and physicians to attempt in vain to do so.

For the reasons set forth herein, the Petitioners respectfully request that this Court grant their Petition for Writ of Certiorari.

Respectfully submitted,



Julia Krebs-Markrich*
John E. Coffey
Jennifer L.W. Korjus
HAZEL & THOMAS, P.C.
3110 Fairview Park Drive
Suite 1400
Falls Church, Virginia 22042
Tel: (703) 641-4200
Case No. 93-1899L

*Counsel of Record

Pleasant S. Brodnax, III
2861 Duke Street
Alexandria, Virginia 22314
Tel: (703) 751-1110
Case No. 93-1924

Kenneth E. Labowitz
YOUNG, GOLDMAN
AND VAN BEEK
510 King Street
P.O. Box 1946
Alexandria, Virginia 22313
Tel: (703) 684-3260
Case No. 93-1923

Counsel for Petitioners

June 24, 1994

No. ____

IN THE

Supreme Court of the United States

OCTOBER TERM, 1994

IN THE MATTER OF BABY K

Petition for Writ of Certiorari to the
United States Court of Appeals
For the Fourth Circuit

CERTIFICATE OF SERVICE

I hereby certify that on this 24th day of June 1994, in compliance with Rule 29 of the Rules of the United States Supreme Court, three true copies of the foregoing Petition for Writ of Certiorari were sent by first class mail, postage prepaid, to:

Ellen J. Flannery
COVINGTON & BURLING
1201 Pennsylvania Avenue, N.W.
P.O. Box 7566
Washington, D.C. 20044
Counsel for Ms. H

Julia Krebs-Markrich
Counsel of Record

United States Court of Appeals for the Fourth Circuit.

In the Matter of BABY "K" (Three Cases).

Nos. 93-1899, 93-1923 and 93-1924

Argued October 26, 1993.

Decided February 10, 1994.

Before WILKINS and WILLIAMS, Circuit Judges, and SPROUSE, Senior Circuit Judge.

OPINION

WILKINS, Circuit Judge:

The Hospital[1] instituted this action against Ms. H, Mr. K, and Baby K, seeking a declaratory judgment that it is not required under the Emergency Medical Treatment and Active Labor Act (EMTALA), 42 U.S.C.A. § 1395dd (West 1992),[2] to provide treatment other than warmth, nutrition, and hydration

---

[1] Due to the parties' request for anonymity, all identifying information has been omitted from this opinion and anonyms are used to refer to the parties.

[2] The Hospital also sought declaratory relief under § 504 of the Rehabilitation Act of 1973 (Rehabilitation Act), 29 U.S.C.A. § 794 (West. Supp. 1993); the Americans with Disabilities Act of 1990 (ADA), 42 U.S.C.A. §§ 12101 *et seq.* (West 1993); the Child Abuse Prevention and Treatment Act (Child Abuse Act), 42 U.S.C.A. §§ 5101-5106h (West Supp. 1993); and the statutes and common law of Virginia. In addressing these provisions, the district court concluded that a failure to provide respiratory support to Baby K because of her condition of anencephaly would constitute discrimination in violation of the ADA and the Rehabilitation Act but declined to rule on the application of the Child Abuse Act or Virginia law. Because we conclude that the Hospital has a duty to render stabilizing treatment under EMTALA, we need not address its obligations under the remaining federal statutes or the laws of Virginia.

to Baby K, an anencephalic infant. Because we agree with the district court, 832 F.Supp. 1022, that EMTALA gives rise to a duty on the part of the Hospital to provide respiratory support to Baby K when she is presented at the Hospital in respiratory distress and treatment is requested for her, we affirm.

I.

Baby K was born at the Hospital in October of 1992 with anencephaly, a congenital malformation in which a major portion of the brain, skull, and scalp are missing. While the presence of a brain stem does support her autonomic functions and reflex actions, because Baby K lacks a cerebrum, she is permanently unconscious. Thus, she has no cognitive abilities or awareness. She cannot see, hear, or otherwise interact with her environment.

When Baby K had difficulty breathing on her own at birth, Hospital physicians placed her on a mechanical ventilator. This respiratory support allowed the doctors to confirm the diagnosis and gave Ms. H, the mother, an opportunity to fully understand the diagnosis and prognosis of Baby K's condition. The physicians explained to Ms. H that most anencephalic infants die within a few days of birth due to breathing difficulties and other complications. Because aggressive treatment would serve no therapeutic or palliative purpose, they recommended that Baby K only be provided with supportive care in the form of nutrition, hydration, and warmth. Physicians at the Hospital also discussed with Ms. H the possibility of a "Do Not Resuscitate Order" that would provide for the withholding of lifesaving measures in the future.

The treating physicians and Ms. H failed to reach an agreement as to the appropriate care. Ms. H insisted that Baby K be provided with mechanical breathing assistance whenever the infant developed difficulty breathing on her own, while the physicians maintained that such care was inappropriate. As a

result of this impasse, the Hospital sought to transfer Baby K to another hospital. This attempt failed when all of the hospitals in the area with pediatric intensive care units declined to accept the infant. In November of 1992, when Baby K no longer needed the services of an acute-care hospital, she was transferred to a nearby nursing home.

Since being transferred to the nursing home, Baby K has been readmitted to the Hospital three times due to breathing difficulties. Each time she has been provided with breathing assistance and, after stabilization, has been discharged to the nursing home. Following Baby K's second admission, the Hospital filed this action to resolve the issue of whether it is obligated to provide emergency medical treatment to Baby K that it deems medically and ethically inappropriate. Baby K's guardian *ad litem* and her father, Mr. K, joined in the Hospital's request for a declaration that the Hospital is not required to provide respiratory support or other aggressive treatments. Ms. H contested the Hospital's request for declaratory relief. After the district court issued its findings of fact and conclusions of law denying the requested relief, the Hospital, Mr. K, and Baby K's guardian *ad litem* (collectively referred to as the "Hospital") noticed this appeal.

II.

Congress enacted EMTALA in response to its "concern that hospitals were 'dumping' patients [who were] unable to pay, by either refusing to provide emergency medical treatment or transferring patients before their emergency conditions were stabilized." *Brooks v. Maryland Gen. Hosp. Inc.*, 996 F.2d 708, 710 (4th Cir. 1993). Through EMTALA, Congress sought "to provide an 'adequate first response to a medical crisis' for all patients," *Baber v. Hospital Corp. of America*, 977 F.2d 872, 880 (4th Cir. 1992) (quoting 131 Cong. Rec. S13904 (daily ed. Oct. 23, 1985) (statement of Sen. Dole)); *see also Brooker v. Desert Hosp. Corp.*, 947 F.2d 412, 415 (9th Cir. 1991) (holding

that EMTALA applies "to any and all patients"); *Gatewood v. Washington Healthcare Corp.*, 933 F.2d 1037, 1040 (D.C. Cir. 1991) (same); *Cleland v. Bronson Health Care Group, Inc.*, 917 F.2d 266, 268 (6th Cir. 1990) (same), by imposing two duties on hospitals that have entered into Medicare provider agreements.

First, those hospitals with an emergency medical department must provide an appropriate medical screening to determine whether an emergency medical condition exists for any individual who comes to the emergency medical department requesting treatment. 42 U.S.C.A. § 1395dd(a).[3] A hospital fulfills this duty if it utilizes identical screening procedures for all patients complaining of the same condition or exhibiting the same symptoms. *See Baber*, 977 F.2d at 879 n. 6.

An additional duty arises if an emergency medical condition is discovered during the screening process. *See* 42 U.S.C.A. § 1395dd(b). EMTALA defines an "emergency medical condition" as including:

> a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in —

---

[3] The full text of subsection (a) provides:

> In the case of a hospital that has a hospital emergency department, if any individual (whether or not eligible for benefits under this subchapter) comes to the emergency department and a request is made on the individual's behalf for examination or treatment for a medical condition, the hospital must provide for an appropriate medical screening examination within the capability of the hospital's emergency department, including ancillary services routinely available to the emergency department, to determine whether or not an emergency medical condition (within the meaning of subsection (e)(1) of this section) exists.

42 U.S.C.A. § 1395dd(a).

> (i) placing the health of the individual . . . in serious jeopardy,
>
> (ii) serious impairment to bodily functions, or
>
> (iii) serious dysfunction of any bodily organ or part.

42 U.S.C.A. § 1395dd(e)(1)(A).[4] When an individual is diagnosed as presenting an emergency medical condition:

> the hospital must provide either —
>
> (A) within the staff and facilities available at the hospital, for such further medical examination and such treatment as may be required to stabilize the medical condition, or
>
> (B) for the transfer of the individual to another medical facility in accordance with subsection (c) of this section.

42 U.S.C.A. § 1395dd(b)(1). The treatment required "to stabilize" an individual is that treatment "necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility." 42 U.S.C.A. § 1395dd(e)(3)(A). Therefore, once an individual has been diagnosed as presenting an emergency medical condition, the hospital must provide that treatment necessary to prevent the material deterioration of the

---

[4] A pregnant woman who is having contractions also qualifies as being in an "emergency medical condition" if:

> (i) . . . there is inadequate time to effect a safe transfer to another hospital before delivery, or
>
> (ii) . . . transfer may pose a threat to the health or safety of the woman or unborn child.

42 U.S.C.A. § 1395dd(e)(1)(B). This portion of the statute is not applicable to the appeal before us.

individual's condition or provide for an appropriate transfer to another facility.

In the application of these provisions to Baby K, the Hospital concedes that when Baby K is presented in respiratory distress a failure to provide "immediate medical attention" would reasonably be expected to cause serious impairment of her bodily functions. *See* 42 U.S.C.A. § 1395dd(e)(1)(A). Thus, her breathing difficulty qualifies as an emergency medical condition, and the diagnosis of this emergency medical condition triggers the duty of the hospital to provide Baby K with stabilizing treatment or to transfer her in accordance with the provisions of EMTALA. Since transfer is not an option available to the Hospital at this juncture,[5] the Hospital must stabilize Baby K's condition.

The Hospital acknowledged in its complaint that aggressive treatment, including mechanical ventilation, is necessary to "assure within a reasonable medical probability, that no material deterioration of Baby K's condition is likely to occur." Thus,

---

[5] In order for a hospital to transfer a patient prior to stabilization, EMTALA requires: (1) the patient or a person acting on the patient's behalf to request a transfer in writing after being informed of the risks involved and the obligations of the hospital under EMTALA; or (2) a proper certification that the medical benefits expected from the transfer outweigh the risks involved. 42 U.S.C.A. § 1395dd(c)(1). In addition, the transfer must meet the criteria for an appropriate transfer which include the requirement that a qualified receiving facility agree to accept the patient and to provide appropriate medical treatment. 42 U.S.C.A. § 1395dd(c)(1)(B), (c)(2). Since Ms. H objects to the transfer of Baby K, since the Hospital has not obtained a certification that the benefits of a transfer would outweigh the medical risks involved, and since no qualified medical facility has agreed to accept Baby K, the requirements for transfer prior to stabilization have not been met. If Ms. H requests a transfer or the Hospital obtains a certification that the benefits of a transfer would outweigh the risks involved, and all of the requirements for an appropriate transfer are met, then the Hospital could, of course, transfer Baby K to another qualified medical facility prior to stabilization.

stabilization of her condition requires the Hospital to provide respiratory support through the use of a respirator or other means necessary to ensure adequate ventilation. In sum, a straightforward application of the statute obligates the Hospital to provide respiratory support to Baby K when she arrives at the emergency department[6] of the Hospital in respiratory distress and treatment is requested on her behalf.[7]

III.

In an effort to avoid the result that follows from the plain language of EMTALA, the Hospital offers four arguments. The Hospital claims: (1) that this court has previously interpreted EMTALA as only requiring uniform treatment of all patients exhibiting the same condition; (2) that in prohibiting disparate emergency medical treatment Congress did not intend to require physicians to provide treatment outside the prevailing standard of medical care; (3) that an interpretation of EMTALA that requires a hospital or physician to provide respiratory support

---

[6] It is not clear from the record whether the movement of Baby K from the nursing home to the Hospital constitutes a discharge from the nursing home and presentation at the emergency department of the Hospital or a transfer to the Hospital. Subsection (g) of EMTALA provides that participating hospitals that have "specialized capabilities or facilities (such as . . . neonatal intensive care units . . .) *shall not refuse* to accept an appropriate transfer of an individual who requires such specialized capabilities or facilities if the hospital has the capacity to treat the individual." 42 U.S.C.A. § 1395dd(g) (emphasis added). When she experiences respiratory distress, Baby K requires specialized facilities and capabilities that the nursing home does not possess. The Hospital admittedly does possess these facilities and capabilities, including mechanical ventilators and a pediatric intensive care unit. Thus, irrespective of whether the movement of Baby K between the two facilities constitutes a discharge and presentment or a transfer, acceptance and treatment by the Hospital is required.

[7] The provisions of EMTALA would not, of course, be limited to the condition of respiratory distress or the provision of respiratory support. Any diagnosed "emergency medical condition" experienced by Baby K would require stabilizing treatment unless an appropriate transfer could be effected.

to an anencephalic infant fails to recognize a physician's ability, under Virginia law, to refuse to provide medical treatment that the physician considers medically or ethically inappropriate; and (4) that EMTALA only applies to patients who are transferred from a hospital in an unstable condition. We find these arguments unavailing.[8]

A.

Relying on the decisions of this court in *Baber v. Hospital Corp. of America*, 977 F.2d 872 (4th Cir. 1992), and *Brooks v. Maryland Gen. Hosp. Inc.*, 996 F.2d 708 (4th Cir. 1993), the Hospital contends that it is only required to provide Baby K with the same treatment that it would provide other anencephalic infants — supportive care in the form of warmth, nutrition, and hydration. The Hospital quotes language from *Baber* and *Brooks* as supporting the proposition that EMTALA only requires participating hospitals to provide uniform treatment to all patients exhibiting the same emergency medical condition. Advancing the proposition that anencephaly, as opposed to respiratory distress, is the emergency medical condition at issue, the Hospital concludes that it is only required to provide uniform treatment to all anencephalic infants. We disagree.

In *Baber* and *Brooks*, this court addressed the "appropriate medical screening" requirement of EMTALA. In the absence of a statutory definition for this term, we concluded that it should be defined as requiring participating hospitals to apply uniform screening procedures to all individuals coming to the emergency room of the hospital requesting treatment. *Baber*, 977 F.2d at 880; *Brooks*, 996 F.2d at 710-11. These cases dealt with screening procedures; neither addressed a hospital's duty to provide stabilizing treatment for an emergency medical condition.

---

[8] Because the issues presented raise questions of statutory interpretation, we conduct a de novo review. *Baber*, 977 F.2d at 876.

With this issue now before us, we conclude that the duty of the Hospital to provide stabilizing treatment for an emergency medical condition is not coextensive with the duty of the Hospital to provide an "appropriate medical screening." Congress has statutorily defined the duty of a hospital to provide stabilizing treatment as requiring that treatment necessary to prevent the material deterioration of a patient's condition. 42 U.S.C.A. § 1395dd(e)(3)(A). If, as the Hospital suggests, it were only required to provide uniform treatment, it could provide any level of treatment to Baby K, including a level of treatment that would allow her condition to materially deteriorate, so long as the care she was provided was consistent with the care provided to other individuals. *See Baber*, 977 F.2d at 879 n. 7 ("[H]ospitals could theoretically avoid liability by providing very cursory and substandard screenings to all patients...."). The definition of stabilizing treatment advocated by the Hospital directly conflicts with the plain language of EMTALA.

As we have previously stated, "it is not our role to rewrite legislation passed by Congress. When a statute is clear and unambiguous, we must apply its terms as written." *Baber*, 977 F.2d at 878. The terms of EMTALA as written do not allow the Hospital to fulfill its duty to provide stabilizing treatment by simply dispensing uniform treatment. Rather, the Hospital must provide that treatment necessary to prevent the material deterioration of each patient's emergency medical condition. In the case of Baby K, the treatment necessary to prevent the material deterioration of her condition when she is in respiratory distress includes respiratory support.

Even if this court were to interpret EMTALA as requiring hospitals to provide uniform treatment for emergency medical conditions, we could not find that the Hospital is only required to provide Baby K with warmth, nutrition, and hydration. As the Hospital acknowledged during oral argument, Baby K resides at the nursing home for months at a time without requiring

emergency medical attention. Only when she has experienced episodes of bradypnea or apnea[9] has Baby K required respiratory support to prevent serious impairment of her bodily functions. It is bradypnea or apnea, not anencephaly, that is the emergency medical condition that brings Baby K to the Hospital for treatment. Uniform treatment of emergency medical conditions would require the Hospital to provide Baby K with the same treatment that the Hospital provides all other patients experiencing bradypnea or apnea. The Hospital does not allege that it would refuse to provide respiratory support to infants experiencing bradypnea or apnea who do not have anencephaly. Indeed, a refusal to provide such treatment would likely be considered as providing *no* emergency medical treatment. *See Baber*, 977 F.2d at 879 n. 7 (stating that the provision of cursory medical screenings might be considered a failure to screen).

B.

The second argument of the Hospital is that, in redressing the problem of disparate emergency medical treatment, Congress did not intend to require physicians to provide medical treatment outside the prevailing standard of medical care. The Hospital asserts that, because of their extremely limited life expectancy and because any treatment of their condition is futile, the prevailing standard of medical care for infants with anencephaly is to provide only warmth, nutrition, and hydration. Thus, it maintains that a requirement to provide respiratory assistance would exceed the prevailing standard of medical care. However, the plain language of EMTALA requires stabilizing treatment for any individual who comes to a participating hospital, is diagnosed as having an emergency medical condition, and cannot be transferred. 42 U.S.C.A. § 1395dd(b). "[I]n the

---

[9] Bradypnea is an "abnormal slowness of breathing." Dorland's Illustrated Medical Dictionary 230 (27th ed. 1988). In an infant who has established and sustained spontaneous breathing, apnea describes the cessation of respiration for more than 60 seconds. *Id.* at 112.

absence of 'a clearly expressed legislative intent to the contrary,'" unambiguous statutory language is ordinarily conclusive. *United States v. Blackwell*, 946 F.2d 1049, 1052 (4th Cir. 1991) (quoting *Russello v. United States*, 464 U.S. 16, 20, 104 S.Ct. 296, 299, 78 L.Ed.2d 17 (1983)). The Hospital has been unable to identifv, nor has our research revealed, any statutory language or legislative history evincing a Congressional intent to create an exception to the duty to provide stabilizing treatment when the required treatment would exceed the prevailing standard of medical care. We recognize the dilemma facing physicians who are requested to provide treatment they consider morally and ethically inappropriate, but we cannot ignore the plain language of the statute because "to do so would 'transcend our judicial function.'" *Baber*, 977 F.2d at 884 (quoting *Iselin v. United States*, 270 U.S. 245, 250-51, 46 S.Ct. 248, 250, 70 L.Ed. 566 (1926). The appropriate branch to redress the policy concerns of the Hospital is Congress.

C.

The Hospital further argues that EMTALA cannot be construed to require it to provide respiratory support to anencephalics when its physicians deem such care inappropriate, because Virginia law permits physicians to refuse to provide such care. Section 54.1-2990 of the Health Care Decisions Act (HCDA) of Virginia provides that "[n]othing in this article shall be construed to require a physician to prescribe or render medical treatment to a patient that the physician determines to be medically or ethically inappropriate." Va. Code Ann. § 54.1-2990 (Michie Supp. 1993). The Hospital maintains that EMTALA only obligates a hospital to provide stabilizing treatment "within the staff and facilities available at the hospital," 42 U.S.C.A. § 1395dd(b)(1)(A). It reasons that because its physicians object to providing respiratory support to anencephalics, it has no physicians available to provide respira-

tory treatment for Baby K and, therefore, is not required by EMTALA to provide such treatment. We disagree.

The duty to provide stabilizing treatment set forth in EMTALA applies not only to participating hospitals but also to treating physicians in participating hospitals. 42 U.S.C.A. § 1395dd(d)(1)(B). EMTALA does not provide an exception for stabilizing treatment physicians may deem medically or ethically inappropriate. Consequently, to the extent § 54.1-2990 exempts physicians from providing care they consider medically or ethically inappropriate, it directly conflicts with the provisions of EMTALA that require stabilizing treatment to be provided.

It is well settled that state action must give way to federal legislation where a valid "act of Congress, fairly interpreted, is in actual conflict with the law of the state," *Savage v. Jones*, 225 U.S. 501, 533, 32 S.Ct. 715, 726, 56 L.Ed. 1182 (1912), and EMTALA provides that state and local laws that directly conflict with the requirements of EMTALA are preempted. 42 U.S.C.A. § 1395dd(f). The Hospital does not allege that EMTALA is an invalid act of Congress. Therefore, to the extent that § 54.1-2990 applies to medical treatment decisions on behalf of infants[10] and to the extent that § 54.1-2990 exempts treating physicians in participating hospitals from providing care they consider medically or ethically inappropriate, it is preempted — it does not allow the physicians treating Baby K to refuse to provide her with respiratory support.

---

[10] By its terms the application of § 54.1-2990 is limited to the HCDA, Va. Code Ann. §§ 54.1-2981 to 54.1-2993 (Michie Supp. 1993). The HCDA governs advance medical directives by adults and surrogate medical treatment decisions on behalf of adults. No part of the HCDA sets forth provisions for dealing with medical treatment decisions on behalf of infants. Therefore, the Virginia legislature presumably did not intend § 54.1-2990 to apply to medical treatment decisions on behalf of infants.

D.

[8] The final contention advanced by the Hospital is that EMTALA only applies to patients who are transferred from a hospital in an unstable condition. The Hospital grounds this argument on the definition of stabilizing treatment as that treatment "necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the *transfer* of the individual from a facility." 42 U.S.C.A. § 1395dd(e)(3)(A) (emphasis added). According to the Hospital, the use of the word "transfer" limits the duty of hospitals and physicians to provide stabilizing treatment to situations in which the patient is to be subsequently transferred to another facility. The end result of this reasoning would allow hospitals and physicians to avoid providing stabilizing treatment by simply refusing to transfer the patient or, as in the case of Baby K, elect not to provide stabilizing treatment because other hospitals will not accept a transfer.

As previously stated, § 1395dd(b) requires a hospital to provide stabilizing treatment to any individual who comes to a participating hospital, is diagnosed as presenting an emergency medical condition, and cannot be transferred in accordance with the provisions of subsection (c). The use of the word "transfer" to describe the duty of a hospital to provide stabilizing treatment evinces a Congressional intent to require stabilization prior to discharge or that treatment necessary to prevent material deterioration of the patient's condition during transfer. It was not intended to allow hospitals and physicians to avoid liability under EMTALA by accepting and screening a patient and then refusing to treat the patient because the patient cannot or will not be transferred. *See, e.g., Thornton v. Southwest Detroit Hosp.*, 895 F.2d 1131, 1134 (6th Cir. 1990) ("Once a patient is found to suffer from an emergency medical condition, the hospital must give the patient treatment to stabilize that condition unless the patient can be transferred without danger of the

patient's condition deteriorating."); *Burditt v. U.S. Dept. of Health & Human Services*, 934 F.2d 1362, 1368 (5th Cir. 1991) ("Patients diagnosed with an 'emergency medical condition' . . . must either be treated or be transferred. . . ."). The argument of the Hospital to the contrary is without merit.

IV.

It is beyond the limits of our judicial function to address the moral or ethical propriety of providing emergency stabilizing medical treatment to anencephalic infants. We are bound to interpret federal statutes in accordance with their plain language and any expressed congressional intent. Congress rejected a case-by-case approach to determining what emergency medical treatment hospitals and physicians must provide and to whom they must provide it; instead, it required hospitals and physicians to provide stabilizing care to any individual presenting an emergency medical condition. EMTALA does not carve out an exception for anencephalic infants in respiratory distress any more than it carves out an exception for comatose patients, those with lung cancer, or those with muscular dystrophy — all of whom may repeatedly seek emergency stabilizing treatment for respiratory distress and also possess an underlying medical condition that severely affects their quality of life and ultimately may result in their death. Because EMTALA does not provide for such an exception, the judgment of the district court is affirmed.

AFFIRMED.

SPROUSE, Senior Circuit Judge, dissenting:

I respectfully dissent.

I have no quarrel with the majority's conclusion that the duty imposed on hospitals by EMTALA to provide stabilizing treatment for an emergency condition is different from its duty to provide "appropriate medical screening." There is no question that once a medical condition is characterized as an "emer-

gency medical condition" contemplated by EMTALA, the patient must be stabilized to prevent material deterioration of the condition. 42 U.S.C.A. §§ 1395dd(b)(1)(A), (e)(3)(A) (Supp. 1991).

I simply do not believe, however, that Congress, in enacting EMTALA, meant for the judiciary to superintend the sensitive decision-making process between family and physicians at the bedside of a helpless and terminally ill patient under the circumstances of this case. Tragic end-of-life hospital dramas such as this one do not represent phenomena susceptible of uniform legal control. In my view, Congress, even in its weakest moments, would not have attempted to impose federal control in this sensitive, private area. Rather, the statute was designed narrowly to correct a specific abuse: hospital "dumping" of indigent or uninsured emergency patients. *Brooks v. Maryland Gen. Hosp., Inc.*, 996 F.2d 708, 710 (4th Cir. 1993); *Baber v. Hospital Corp. of America*, 977 F.2d 872, 880 (4th Cir. 1992). There is no indication in the legislative history of EMTALA that Congress meant to extend the statute's reach to hospital-patient relationships that do not involve "dumping." Clearly, there is no suggestion of patient "dumping" in this case. To the contrary, Baby K's introduction to the hospital was not for emergency treatment — she was born there. She was twice readmitted and after her subsidiary medical condition was stabilized, transferred back to a nursing home. In light of the purposes of the statute and this child's unique circumstances, I would find this case to be outside the scope of EMTALA's anti-dumping provisions.

I also submit that EMTALA's language concerning the type and extent of emergency treatment to be extended to all patients was not intended to cover the continued emergencies that typically attend patients like Baby K. The law was crafted to effect the purpose of preventing disparate treatment between emergency patients. *See* H.R. Rep. No. 241, 99th Cong., 2d

Sess., pt. 1 at 27 (1986), *reprinted in* 1986 U.S.C.A.A.N. 42, 579, 605. In my view, Baby K is not that kind of emergency patient contemplated by the statute, although by the very nature of her terminal illness, she will suffer repeated medical emergencies during her day-to-day maintenance care. The hospital argues that anencephaly, not the subsidiary respiratory failure, is the condition that should be reviewed in order to judge the applicability *vel non* of EMTALA. I agree. I would consider anencephaly as the relevant condition and the respiratory difficulty as one of many subsidiary conditions found in a patient with the disease. EMTALA was not designed to reach such circumstances.

The tragic phenomenon Baby K represents exemplifies the need to take a case-by-case approach to determine if an emergency episode is governed by EMTALA. Baby K's condition presents her parents and doctors with decision-making choices that are different even from the difficult choices presented by other terminal diseases. Specifically, as an anencephalic infant, Baby K is permanently unconscious. She cannot hear, cannot see, and has no cognitive abilities. She has no awareness of and cannot interact with her environment in any way. Since there is no medical treatment that can improve her condition, she will be in this state for as long as she lives. Given this unique medical condition, whatever treatment appropriate for her unspeakably tragic illness should be regarded as a continuum, not as a series of discrete emergency medical conditions to be considered in isolation. Humanitarian concerns dictate appropriate care. However, if resort must be had to our courts to test the appropriateness of the care, the legal vehicle should be state malpractice law.

In my view, considering the discrete factual circumstances of Baby K's condition and previous treatment, if she is transferred again from the nursing home to the hospital in respiratory distress, that condition should be considered integral to the

anencephalic condition, and I would hold that there has been no violation of EMTALA. I emphasize that this view contemplates a case-by-case determination. Individual cases involving victims of trauma, cancer, heart attack, or other catastrophic illness, who are denied potentially life-saving treatments, may well require different analyses.

United States District Court
for the Eastern District of Virginia
(Alexandria Division)

In the Matter of BABY K
Civ. A. No. 93-68-A (Filed Under Seal).
July 1, 1993.

FINDINGS OF FACT AND
CONCLUSIONS OF LAW

HILTON, District Judge.

This case was tried before the court, and upon the evidence presented and argument of counsel, the court makes the following Findings of Fact and Conclusions of Law.

Findings of Fact

1. Plaintiff Hospital is a general acute care hospital located in Virginia that is licensed to provide diagnosis, treatment, and medical and nursing services to the public as provided by Virginia law. Among other facilities, the Hospital has a Pediatric Intensive Care Department and an Emergency Department.

2. The Hospital is a recipient of federal and state funds including those from Medicare and Medicaid and is a "participating hospital" pursuant to 42 U.S.C. § 1395cc.

3. The Hospital and its staff (including emergency doctors, pediatricians, neonatologists and pediatric intensivists) treat sick children on a daily basis.

4. Defendant Ms. H, a citizen of the Commonwealth of Virginia, is the biological mother of Baby K, an infant girl born by Caesarean section at the Hospital on October 13, 1992. Baby K was born with anencephaly.

5. Anencephaly is a congenital defect in which the brain stem is present but the cerebral cortex is rudimentary or absent. There is no treatment that will cure, correct, or ameliorate

anencephaly. Baby K is permanently unconscious and cannot hear or see. Lacking a cerebral function, Baby K does not feel pain. Baby K has brain stem functions primarily limited to reflexive actions such as feeding reflexes (rooting, sucking, swallowing), respiratory reflexes (breathing, coughing), and reflexive responses to sound or touch. Baby K has a normal heart rate, blood pressure, liver function, digestion, kidney function, and bladder function and has gained weight since her birth. Most anencephalic infants die within days of birth.

6. Baby K was diagnosed prenatally as being anencephalic. Despite the counselling of her obstetrician and neonatologist that she terminate her pregnancy, Ms. H refused to have her unborn child aborted.

7. A Virginia court of competent jurisdiction has found defendant Mr. K, a citizen of the Commonwealth of Virginia, to be Baby K's biological father.

8. Ms. H and Mr. K have never been married.

9. Since Baby K's birth, Mr. K has, at most, been only distantly involved in matters relating to the infant. Neither the Hospital nor Ms. H ever sought Mr. K's opinion or consent in providing medical treatment to Baby K.

10. Because Baby K had difficulty breathing immediately upon birth, Hospital physicians provided her with mechanical ventilator treatment to allow her to breathe.

11. Within days of Baby K's birth, Hospital medical personnel urged Ms. H to permit a "Do Not Resuscitate Order" for Baby K that would discontinue ventilator treatment. Her physicians told her that no treatment existed for Baby K's anencephalic condition, no therapeutic or palliative purpose was served by the treatment, and that ventilator care was medically unnecessary and inappropriate. Despite this pressure, Ms. H continued to request ventilator treatment for her child.

12. Because of Ms. H's continued insistence that Baby K receive ventilator treatment, her treating physicians requested the assistance of the Hospital's "Ethic Committee" in overriding the mother's wishes.

13. A three person Ethics Committee subcommittee, composed of a family practitioner, a psychiatrist, and a minister, met with physicians providing care to Baby K. On October 22, 1992, the group concluded that Baby K's ventilator treatment should end because "such care is futile" and decided to "wait a reasonable time for the family to help the caregiver terminate aggressive therapy." If the family refused to follow this advice, the committee recommended that the Hospital should "attempt to resolve this through our legal system."

14. Ms. H subsequently rejected the committee's recommendation. Before pursuing legal action to override Ms. H's position, the Hospital decided to transfer the infant to another health care facility.

15. Baby K was transferred to a nursing home ("Nursing Home") in Virginia on November 30, 1992 during a period when she was not experiencing respiratory distress and thus did not need ventilator treatment. A condition of the transfer was that the Hospital agreed to take the infant back if Baby K again developed respiratory distress to receive ventilator treatment which was unavailable at the Nursing Home. Ms. H agreed to this transfer.

16. Baby K returned to the Hospital on January 15, 1993 after experiencing respiratory distress to receive ventilator treatment. Hospital officials again attempted to persuade Ms. H to discontinue ventilator treatment for her child. Ms. H again refused. After Baby K could breathe on her own, she was transferred back to the Nursing Home on February 12, 1993.

17. Baby K again experienced breathing difficulties on March 3, 1993 and returned to the Hospital to receive ventilator treatment.

18. On March 15, 1993, Baby K received a tracheotomy, a procedure in which a breathing tube is surgically implanted in her windpipe, to facilitate ventilator treatment. Ms. H agreed to this operation.

19. After no longer requiring ventilator treatment, Baby K was transferred back to the Nursing Home on April 13, 1993 where she continues to live.

20. Baby K will almost certainly continue to have episodes of respiratory distress in the future. In the absence of ventilator treatment during these episodes, she would suffer serious impairment of her bodily functions and soon die.

21. Ms. H visits Baby K daily. The mother opposes the discontinuation of ventilator treatment when Baby K experiences respiratory distress because she believes that all human life has value, including her anencephalic daughter's life. Ms. H has a firm Christian faith that all life should be protected. She believes that God will work a miracle if that is his will. Otherwise, Ms. H believes, God, and not other humans, should decide the moment of her daughter's death. As Baby K's mother and as the only parent who has participated in the infant's care, Ms. H believes that she has the right to decide what is in her child's best interests.

22. On the Hospital's motion, a guardian *ad litem* to represent Baby K was appointed pursuant to Virginia Code § 8.01-9.

23. Both the guardian *ad litem* and Mr. K share the Hospital's position that ventilator treatment should be withheld from Baby K when she experiences respiratory distress.

24. The Hospital has stipulated that it is not proposing to deny ventilator treatment to Baby K because of any lack of

adequate resources or any inability of Ms. H to pay for the treatment.

Conclusions of Law

Pursuant to the Declaratory Judgment Act, 28 U.S.C. § 2201, the Hospital has sought declaratory and injunctive relief under four federal statutes and one Virginia statute: the Emergency Medical Treatment and Active Labor Act, 42 U.S.C. § 1395dd; the Rehabilitation Act of 1973, 29 U.S.C. § 794; the Americans with Disabilities Act of 1990, 42 U.S.C. § 12101 *et seq.*; the Child Abuse Amendments of 1984, 42 U.S.C. § 5102 *et seq.*; and the Virginia Medical Malpractice Act, Va. Code § 8.01-581.1 *et seq.* This court has federal question jurisdiction under the four federal statutes and supplemental jurisdiction regarding the Virginia statute. 28 U.S.C. §§ 1331, 1367.

I. Emergency Medical Treatment and Active Labor Act

Plaintiff seeks a declaration that its refusal to provide Baby K with life-supporting medical care would not transgress the Emergency Medical Treatment and Active Labor Act, 42 U.S.C. § 1395dd ("EMTALA"). EMTALA requires that participating hospitals provide stabilizing medical treatment to any person who comes to an emergency department in an "emergency medical condition" when treatment is requested on that person's behalf. An "emergency medical condition" is defined in the statute as "acute symptoms of sufficient severity . . . such that the absence of immediate medical attention could reasonably be expected to result in . . . serious impairment to bodily functions, or serious dysfunction of any bodily organ or part." 42 U.S.C. § 1395dd(e)(1)(A). "Stabilizing" medical treatment is defined as "such medical treatment of the condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition" will result. *Id.* § 1395dd(e)(3)(A). The statute's legislative history includes a

position paper by the American College of Emergency Physicians stating that "stabilization" should include "[e]stablishing and assuring an adequate airway and adequate ventilation." H.R. Rep. No. 241 (Pt. 3), 99th Cong., 1st Sess. 26 (1985).

The Hospital admits that Baby K would meet these criteria if she is brought to the Hospital while experiencing breathing difficulty. As stated in the Hospital's complaint, when Baby K is in respiratory distress, that condition is "such that the absence of immediate medical attention could reasonably be expected to cause serious impairment to her bodily functions" — *i.e.*, her breathing difficulties constitute an "emergency medical condition." The Hospital also concedes in its complaint that ventilator treatment is required in such circumstances to assure "that no material deterioration of Baby K's condition is likely to occur" — *i.e.*, a ventilator is necessary to "stabilize" the baby's condition. These admissions establish that the Hospital would be liable under EMTALA if Baby K arrived there in respiratory distress (or some other emergency medical condition) and the Hospital failed to provide mechanical ventilation (or some other medical treatment) necessary to stabilize her acute condition.

The Hospital would also have an obligation to continue to provide stabilizing medical treatment to Baby K even if she were admitted to the pediatric intensive care unit or other unit of the Hospital and to provide the treatment until she could be transferred back to the Nursing Home or to another facility willing to accept her. *See Thornton v. Southwest Detroit Hosp.*, 895 F.2d 1131, 1135 (6th Cir. 1990) ("emergency care does not always stop when a patient is wheeled from the emergency room into the main hospital"); *McIntyre v. Schick*, 795 F.Supp. 777, 781 (E.D. Va. 1992) (rationale behind "anti-dumping statute is not based upon the door of the hospital through which a patient enters, but rather upon the notion of proper medical care for those persons suffering medical emergencies, whenever such emergencies occur at a participating hospital. Indeed, it is a

ridiculous distinction, one which places form over substance, to state that the care a patient receives depends on the door through which the patient walks").

Despite EMTALA's clear requirements and in the face of the Hospital's admissions, the Hospital seeks an exemption from the statute for instances in which the treatment at issue is deemed "futile" or "inhumane" by the hospital physicians. The plain language of the statute requires stabilization of an emergency medical condition. The statute does not admit of any "futility" or "inhumanity" exceptions. Any argument to the contrary should be directed to the U.S. Congress, not to the Federal Judiciary. *Cf. Baber v. Hospital Corporation of America*, 977 F.2d 872, 878 (4th Cir. 1992) (rejecting argument that EMTALA provides private cause of action against physicians on grounds that "it is not our role to rewrite legislation passed by Congress. When a statute is clear and unambiguous, we must apply its terms as written instead of varying its terms to accommodate a perceived legislative intent").

Even if EMTALA contained the exceptions advanced by the Hospital, these exceptions would not apply here. The use of a mechanical ventilator to assist breathing is not "futile" or "inhumane" in relieving the *acute* symptoms of respiratory difficulty which is the emergency medical condition that must be treated under EMTALA. To hold otherwise would allow hospitals to deny emergency treatment to numerous classes of patients, such as accident victims who have terminal cancer or AIDS, on the grounds that they eventually will die anyway from those diseases and that emergency care for them would therefore be "futile."

II. Rehabilitation Act

Section 504 of the Rehabilitation Act prohibits discrimination against an "otherwise qualified" handicapped individual, solely by reason of his or her handicap, under any program or activity receiving federal financial assistance. Hospitals such as

plaintiff that accept Medicare and Medicaid funding are subject to the Act. *United States v. Baylor Univ. Medical Center*, 736 F.2d 1039, 1049 (5th Cir. 1984), *cert. denied*, 469 U.S. 1189, 105 S.Ct. 958, 83 L.Ed.2d 964 (1985). Baby K is a "handicapped" and "disabled" person within the meaning of the Rehabilitation Act of 1973. A "handicapped individual" under the Rehabilitation Act "includes an infant who is born with a congenital defect." *Bowen v. American Hospital Ass'n*, 476 U.S. 610, 624, 106 S.Ct. 2101, 2110, 90 L.Ed.2d 584 (1986).

Section 504's plain text spells out the necessary scope of inquiry: Is Baby K otherwise qualified to receive ventilator treatment and is ventilator treatment being threatened with being denied because of an unjustified consideration of her anencephalic handicap? The Hospital has admitted that the sole reason it wishes to withhold ventilator treatment for Baby K over her mother's objections, is because of Baby K's anencephaly - her handicap and disability.

To evade this textual mandate, the Hospital relies on two cases which held that a hospital's decision not to override the desire of the parents of babies with congenital defects to withhold treatment did not violate section 504. *Johnson v. Thompson*, 971 F.2d 1487, 1493 (10th Cir. 1992), *cert. denied*, _____ U.S. ____, 113 S.Ct. 1255, 122 L.Ed.2d 654 (1993); *United States v. University Hospital, State U. of New York*, 729 F.2d 144, 156-57 (2d Cir. 1984). Because the parents in *Johnson* and *University Hospital* consented to the withholding of treatment, the two cases are factually distinguishable from this case.[1]

---

[1] Department of Health and Human Services guidelines addressing hospital reporting obligations under the Act if parents seek to withhold treatment from anencephalic infants are similarly inapplicable because of their silence regarding whether hospitals are allowed to terminate care in spite of a parent's wishes to the contrary. *See* 45 C.F.R. Part 84, App. C., paragraph (a)(5)(iii) (1992).

When the Rehabilitation Act was passed in 1973, Congress intended that discrimination on the basis of a handicap be treated in the same manner that Title VI of the Civil Rights Act treats racial discrimination. *University Hospital*, 729 F.2d at 161-163 (Winter, J., dissenting). This analogy to race dispels any ambiguity about the extent to which Baby K has statutory rights not to be discriminated against on the basis of her handicap. It also shatters the Hospital's contention that ventilator treatment should be withheld because Baby K's recurring breathing troubles are intrinsically related to her handicap. No such distinction would be permissible within the context of racial discrimination. In addition, the Hospital was able to perform a tracheotomy on Baby K. This surgery was far more complicated than linking her to a ventilator to allow her to breathe. *Cf. Bowen*, 476 U.S. at 655, 106 S.Ct. at 2127 ("if an otherwise normal child would be given the identical treatment, so should the handicapped child") (White, J., dictum in dissent). Just as an AIDS patient seeking ear surgery is "otherwise qualified" to receive treatment despite poor long term prospects of living, Baby K is "otherwise qualified" to receive ventilator treatment despite similarly dismal health prospects. *Cf. Glanz v. Vernick*, 750 F. Supp. 39, 45-46 (D. Mass. 1990). Thus, the Hospital's desire to withhold ventilator treatment from Baby K over her mother's objections would violate the Rehabilitation Act.

III. Americans with Disabilities Act

Section 302 of the Americans with Disabilities Act ("ADA") prohibits discrimination against disabled individuals by "public accommodations." 42 U.S.C. § 12182. A "disability" is "a physical or mental impairment that substantially limits one or more of the major life activities" of an individual. 42 U.S.C. § 12102(2). This includes any physiological disorder or condition affecting the neurological system, musculoskeletal system, or sense organs, among others. 28 C.F.R. § 36.104 (definition of "physical or mental impairment"). Anencephaly

is a disability, because it affects the baby's neurological functioning, ability to walk, and ability to see or talk. "Public accommodation" is defined to include a "professional office of a health care provider, hospital, or other service establishment." 42 U.S.C. § 12181(7). The Hospital is a public accommodation under the ADA. 28 C.F.R. § 36.104.

Section 302(a) of the ADA states a general rule of nondiscrimination against the disabled:

> General rule. No individual shall be discriminated against on the basis of disability in the full and equal enjoyment of the goods, services, facilities, privileges, advantages, or accommodation of any place of public accommodations by any person who owns, leases (or leases to), or operates a place of public accommodation.

42 U.S.C. § 12182(a). In contrast to the Rehabilitation Act, the ADA does not require that a handicapped individual be "otherwise qualified" to receive the benefits of participation. Further, section 302(b)(1)(A) of the ADA states that "[i]t shall be discriminatory to subject an individual or class of individuals on the basis of a disability . . . to a denial of the opportunity of the individual or class to participate in or benefit from the goods, services, facilities, privileges, advantages, or accommodations of an entity." 42 U.S.C. § 12182(b)(1)(A)(i).

The Hospital asks this court for authorization to deny the benefits of ventilator services to Baby K by reason of her anencephaly. The Hospital's claim is that it is "futile" to keep alive an anencephalic baby, even though the mother has requested such treatment. But the plain language of the ADA does not permit the denial of ventilator services that would keep alive an anencephalic baby when those life-saving services would otherwise be provided to a baby without disabilities at the parent's request. The Hospital's reasoning would lead to the denial of medical services to anencephalic babies as a class of

disabled individuals. Such discrimination against a vulnerable population class is exactly what the American with Disabilities Act was enacted to prohibit. The Hospital would therefore violate the ADA if it were to withhold ventilator treatment from Baby K.

IV. Child Abuse Act

Plaintiff seeks a declaration that it may refuse to provide life-supporting medical care to Baby K without incurring liability under the Child Abuse Amendments of 1984, 42 U.S.C. § 5101 *et seq.* ("Child Abuse Act"). This request for relief must be denied because the Hospital has failed to join a necessary party - the Virginia Child Protective Services.

There is no private right of action against a health care provider under the Child Abuse Act. *Jensen v. Conrad*, 570 F. Supp. 91, 113 (D.S.C. 1983) (citing *Perry v. Housing Authority of Charleston*, 664 F.2d 1210, 1213 (4th Cir. 1981)), *aff'd*, 747 F.2d 185 (4th Cir. 1984), *cert. denied*, 470 U.S. 1052, 105 S.Ct. 1754, 84 L.Ed.2d 818 (1985). The Act only authorizes states which receive federal grants for child abuse and neglect programs to bring legal action through their child protective services agencies to prevent the medical neglect of disabled infants. 42 U.S.C. § 5106a(b)(10)(C); 45 C.F.R. § 1340.-15(c)(2)(iii).

Because the Virginia Child Protective Services has an interest in a declaratory judgment regarding the Child Abuse Act and is the only party that can enforce the Act, it is a necessary party. This court must have the sole enforcing authority party before it before considering the declaratory judgment issue. *ARW Exploration Corp. v. Aguirre*, 947 F.2d 450, 454 (10th Cir. 1991). Without the Virginia Child Protective Services as a party, no actual controversy exists as to this issue as required by the Declaratory Judgment Act. 28 U.S.C. § 2201. Thus, the Hospital's request for declaratory and injunctive relief under the Child Abuse Amendments must be denied. *See White v. Na-*

tional Union Fire Ins. Co., 913 F.2d 165, 167-168 (4th Cir. 1990).

V. Virginia Medical Malpractice Act

The Hospital seeks a declaration that its refusal to provide Baby K with ventilator treatment does not constitute malpractice under the Virginia Medical Malpractice Act, Va. Code § 8.01-581.1 *et seq.* Under the Declaratory Judgment Act, 28 U.S.C. § 2201, a federal court has discretion to assert jurisdiction to render a declaration. *Mitcheson v. Harris*, 955 F.2d 235 (4th Cir. 1992); Wright & Miller, *Federal Practice and Procedure* § 2759 (1983). This discretion is related to the interest in having states decide questions of state law, an interest having jurisprudential roots in *Erie R.R. Co. v. Tompkins*, 304 U.S. 64, 58 S.Ct. 817, 82 L.Ed. 1188 (1938). *Mitcheson*, 955 F.2d at 237. In the Declaratory Judgment Act, Congress has afforded federal courts a freedom to consider the state interest in having state courts determine questions of state law. *Id.* at 238. Virginia courts have not addressed the question of the appropriate standard of care for anencephalic infants and whether an exception to the general standard of care applies to them. Besides the Malpractice Act's general rule, Virginia's legislature has also been silent on the issue. Moreover, the determination of the standard of care under Virginia's Medical Malpractice Act involves a review panel appointed by the Chief Justice of the Virginia Supreme Court. This review panel mechanism is "so intimately bound up with the rights and obligations being asserted as to require their application in federal courts under the doctrine of *Erie Railroad Co. v. Tompkins*." *DiAntonio v. Northampton-Accomack Memorial Hospital*, 628 F.2d 287, 290 (4th Cir. 1980). Because of the significant state interests manifested by this review process as well as the Commonwealth's interest in resolving this contentious and unsettled social issue for itself, this court declines to "elbow its way" into Virginia medical malpractice standards. *Cf. Mitcheson*, 955 F.2d at 238 (quoting

Pennhurst State School & Hosp. v. Halderman, 465 U.S. 89, 122 n. 32, 104 S.Ct. 900, 920 n. 32, 79 L.Ed.2d 67 (1984)).

VI. Constitutional and Common Law Issues

Baby K's parents disagree over whether or not to continue medical treatment for her. Mr. K and Baby K's guardian *ad litem* join the Hospital in seeking the right to override the wishes of Ms. H, Baby K's mother. Regardless of the questions of statutory interpretation presented in this case, Ms. H retains significant legal rights regarding her insistence that her daughter be kept alive with ventilator treatment. A parent has a constitutionally protected right to "bring up children" grounded in the Fourteenth Amendment's due process clause. *Meyer v. Nebraska*, 262 U.S. 390, 399, 43 S.Ct. 625, 626, 67 L.Ed. 1042 (1923); *Pierce v. Society of Sisters*, 268 U.S. 510, 534-535, 45 S.Ct. 571, 573, 69 L.Ed. 1070 (1925). Parents have the "primary role" in the "nurture and upbringing of their children." *Wisconsin v. Yoder*, 406 U.S. 205, 232, 92 S.Ct. 1526, 1541, 32 L.Ed.2d 15 (1972); *Prince v. Massachusetts*, 321 U.S. 158, 166, 64 S.Ct. 438, 442, 88 L.Ed. 645 (1944). Decisions for children can be based in the parent's free exercise of religion, protected by the First Amendment. *Pierce*, 268 U.S. at 534-535, 45 S.Ct. at 573; *Yoder*, 406 U.S. at 234, 92 S.Ct. at 1542.

These constitutional principles extend to the right of parents to make medical treatment decisions for their minor children. Absent a finding of neglect or abuse, parents retain plenary authority to seek medical care for their children, even when the decision might impinge on a liberty interest of the child. *Parham v. J.R.*, 442 U.S. 584, 603-604, 99 S.Ct. 2493, 2504, 61 L.Ed.2d 101 (1979) (commitment of child to mental health hospital). Indeed, there is a "presumption that the parents act in the best interests of their child" because the "natural bonds of affection lead parents to act in the best interests of their children." *Id.* at 602, 99 S.Ct. at 2504.

State law rights to make medical and surgical treatment decisions for a minor child are grounded in the common law and can also be inferred from state statutes. *See* Va. Code § 54.1-2969(B) (procedure governing consent to treatment of minors when parents are unavailable); Va. Code § 16.1-334(1) (right of emancipated minor to make her own medical care decisions without parental consent).

Based on Ms. H's "natural bonds of affection," *Parham*, 442 U.S. at 602, 99 S.Ct. at 2504, and the relative noninvolvement of Baby K's biological father, the constitutional and common law presumption must be that Ms. H. is the appropriate decision maker. "[W]hen parents do not agree on the issue of termination of life support . . . this Court must yield to the presumption in favor of life." *In re Jane Doe, A Minor*, Civ. No. D-93064, mem. op. at 18 (Super.Ct. Fulton Co., Ga., October 17, 1991), aff'd, 262 Ga. 389, 418 S.E.2d 3 (1992). This presumption arises from the explicit guarantees of a right to life in the United States Constitution, Amendments V and XIV, and the Virginia Constitution, Article 1, Sections 1 and 11.

The presumption in favor of life in this case is also based on Ms. H's religious conviction that all life is sacred and must be protected, thus implicating her First Amendment rights. When an individual asserts "the Free Exercise Clause in conjunction with other constitutional protections, such as . . . the right of parents," only a clear and compelling governmental interest can justify a statute that interferes with the person's religious convictions. *Employment Div., Department of Human Resources of Oregon v. Smith*, 494 U.S. 872, 881 n. 1, 110 S.Ct. 1595, 1601 n. 1, 108 L.Ed.2d 876 (1990); *Yoder*, 406 U.S. at 233, 92 S.Ct. at 1542.

The Hospital cannot establish any "clear and compelling" interest in this case. The Supreme Court has not decided whether the right to liberty encompasses a right to refuse medical treatment, often called a "right to die." *Cruzan v. Director,*

Missouri Dept. of Health, 497 U.S. 261, 277-279, 110 S.Ct. 2841, 2850-51, 111 L.Ed.2d 224 (refusing to decide this question). Parents have standing to assert the constitutional rights of their minor children. *Eisenstadt v. Baird*, 405 U.S. 438, 446 n. 6, 92 S.Ct. 1029 n. 6, 31 L.Ed.2d 349 (1972). When one parent asserts the child's explicit constitutional right to life as the basis for continuing medical treatment and the other is asserting the nebulous liberty interest in refusing life-saving treatment on behalf of a minor child, the explicit right to life must prevail. *See In re Jane Doe, supra.*

Reflecting the constitutional principles of family autonomy and the presumption in favor of life, courts have generally scrutinized a family's decision only where the family has sought to terminate or withhold medical treatment for an incompetent minor or incompetent adult. *See, e.g., Cruzan*, 497 U.S. at 270-75, 110 S.Ct. at 2847-49 (and cases cited therein). In a recent case in which a hospital sought to terminate life-supporting ventilation over the objections of the patient's husband, a Minnesota state court refused to remove decisionmaking authority from the husband. *In re Wanglie*, No. PX-91-283 (Prob. Ct., Hennepin Co., Minn., June 28, 1991). Likewise, where parents disagreed over whether to continue life-supporting mechanical ventilation, nutrition, and hydration for a minor child in an irreversible stupor or coma, a Georgia state court gave effect to the decision of the parent opting in favor of life support. *In re Jane Doe, supra.*[2]

---

[2] Although the court in *Jane Doe* had appointed a guardian *ad litem* because of the parents' disagreement, the guardian's view (if any) was not discussed in the court's ruling. This is consistent with the limited role of a guardian *ad litem* as an independent fact finder and not a surrogate decisionmaker where family members are involved. Under Virginia law, the role of a guardian *ad litem* appointed under Va. Code § 8.01-9(A) is to "investigate thoroughly the facts" and "carefully examine[] the facts surrounding the case." *Ruffin v. Commonwealth*, 10 Va. App. 488, 393 S.E.2d 425

At the very least, the Hospital must establish by clear and convincing evidence that Ms. H's treatment decision should not be respected because it would constitute abuse or neglect of Baby K. This clear and convincing evidence standard has been adopted by numerous courts and was upheld by the Supreme Court in *Cruzan* in authorizing the withdrawal of life-supporting treatment from an incompetent patient. *See Cruzan*, 497 U.S. at 284-85, 110 S.Ct. at 2854-55. In this case, where the choice essentially devolves to a subjective determination as to the quality of Baby's K's life, it cannot be said that the continuation of Baby K's life is so unreasonably harmful as to constitute child abuse or neglect.

For the foregoing reasons, the Hospital's request for a declaratory judgment that the withholding of ventilator treatment from Baby K would not violate the Emergency Medical Treatment and Active Labor Act, the Rehabilitation Act of 1973, the Americans with Disabilities Act, the Child Abuse Amendments of 1984, and the Virginia Medical Malpractice Act should be DENIED. Under the Emergency Medical Treatment and Active Labor Act, the Rehabilitation Act of 1973, and the Americans with Disabilities Act, the Hospital is legally obligated to provide ventilator treatment to Baby K. The court makes no ruling as to any rights or obligations under the Child Abuse Amendments of 1984 and under the Virginia Medical Malpractice Act.

An appropriate order shall issue.

(Va.App.1990). The recommendation of Baby K's court-appointed guardian *ad litem* is thus irrelevant to the disposition of this case.

UNITED STATES COURT OF APPEALS
FOR THE FOURTH CIRCUIT

No. 93-1899(L)
(CA-93-68-A)

IN THE MATTER OF BABY "K"

No. 93-1923
(CA-93-68-A)

IN THE MATTER OF BABY "K"

No. 93-1924
(CA-93-68-A)

IN THE MATTER OF BABY "K"

FILED: March 28, 1994

ORDER

Appellants have filed a petition for rehearing with suggestion for rehearing in banc.

The Court grants the motion of amici curiae American Academy of Pediatrics and Society of Critical Care Medicine

for leave to file a response in support of the petition for rehearing and suggestion for rehearing in banc.

Judges Wilkins and Williams voted to deny the petition for rehearing, and Judge Sprouse voted to grant the petition.

A member of the Court requested a poll on the suggestion for rehearing in banc, the majority of the judges voted to deny rehearing in banc. Judges Russell, Hall, Niemeyer, and Hamilton voted to rehear the case in banc, and Judges Ervin, Widener, Phillips, Murnaghan, Wilkinson, Wilkins, Luttig, Williams, and Michael voted against a rehearing in banc.

The Court denies the petition for rehearing with suggestion for rehearing in banc.

Entered at the direction of Judge Wilkins for the court.

For the Court

/s/ Bert M. Montague
Clerk

§ 1395dd. Examination and treatment for emergency medical conditions and women in labor

(a) Medical screening requirement. In the case of a hospital that has a hospital emergency department, if any individual (whether or not eligible for benefits under this title [42 USCS §§ 1395 et seq.]) comes to the emergency department and a request is made on the individual's behalf for examination or treatment for a medical condition, the hospital must provide for an appropriate medical screening examination within the capability of the hospital's emergency department, including ancillary services routinely available to the emergency department, to determine whether or not an emergency medical condition (within the meaning of subsection (e)(1)) exists.

(b) Necessary stabilizing treatment for emergency medical conditions and labor.

(1) In general. If any individual (whether or not eligible for benefits under this title [42 USCS §§ 1395 et seq.]) comes to a hospital and the hospital determines that the individual has an emergency medical condition, the hospital must provide either—

(A) within the staff and facilities available at the hospital, for such further medical examination and such treatment as may be required to stabilize the medical condition, or

(B) for transfer of the individual to another medical facility in accordance with subsection (c).

(2) Refusal to consent to treatment. A hospital is deemed to meet the requirement of paragraph (1)(A) with respect to an individual if the hospital offers the individual the further medical examination and treatment described in that paragraph and informs the individual (or a person acting on the individual's

behalf) of the risks and benefits to the individual of such examination and treatment, but the individual (or a person acting on the individual's behalf) refuses to consent to the examination and treatment. The hospital shall take all reasonable steps to secure the individual's (or person's) written informed consent to refuse such examination and treatment.

(3) Refusal to consent to transfer. A hospital is deemed to meet the requirement of paragraph (1) with respect to an individual if the hospital offers to transfer the individual to another medical facility in accordance with subsection (c) and informs the individual (or a person acting on the individual's behalf) of the risks and benefits to the individual of such transfer, but the individual (or a person acting on the individual's behalf) refuses to consent to the transfer. The hospital shall take all reasonable steps to secure the individual's (or person's) written informed consent to refuse such transfer.

(c) **Restricting transfers until individual stabilized.**

(1) Rule. If an individual at a hospital has an emergency medical condition which has not been stabilized (within the meaning of subsection (e)(3)(B)), the hospital may not transfer the individual unless—

(A)(i) the individual (or a legally responsible person acting on the individual's behalf) after being informed of the hospital's obligations under this section and of the risk of transfer, in writing requests to transfer to another medical facility,

(ii) a physician (within the meaning of section 1861(r)(1)[42 USCS § 1395x(r)(1)]) has signed a certification

that, based upon the information available at the time of transfer, the medical benefits reasonably expected from the provision of appropriate medical treatment at another medical facility outweigh the increased risks to the individual and, in the case of labor, to the unborn child from effecting the transfer, or

(iii) if a physician is not physically present in the emergency department at the time an individual is transferred, a qualified medical person (as defined by the Secretary in regulations) has signed a certification described in clause (ii) after a physician (as defined in section 1861(r)(1) [42 USCS § 1395x(r)(1)]), in consultation with the person, has made the determination described in such clause, and subsequently countersigns the certification; and

(B) the transfer is an appropriate transfer (within the meaning of paragraph (2)) to that facility. A certification described in clause (ii) or (iii) of subparagraph (A) shall include a summary of the risks and benefits upon which the certification is based.

(2) Appropriate transfer. An appropriate transfer to a medical facility is a transfer—

(A) in which the transferring hospital provides the medical treatment within its capacity which minimizes the risks to the individual's health and, in the case of a woman in labor, the health of the unborn child;

(B) in which the receiving facility—

(i) has available space and qualified personnel for the treatment of the individual, and

(ii) has agreed to accept transfer of the individual and to provide appropriate medical treatment;

(C) in which the transferring hospital sends to the receiving facility with all medical records (or copies thereof), related to the emergency condition for which the individual has presented, available at the time of the transfer, including records related to the individual's emergency medical condition, observations of signs or symptoms, preliminary diagnosis, treatment provided, results of any tests and the informed written consent or certification (or copy thereof) provided under paragraph (1)(A), and the name and address of any on-call physician (described in subsection (d)(1)(C)) who has refused or failed to appear within a reasonable time to provide necessary stabilizing treatment;

(D) in which the transfer is effected through qualified personnel and transportation equipment, as required including the use of necessary and medically appropriate life support measures during the transfer; and

(E) which meets such other requirements as the Secretary may find necessary in the interest of the health and safety of individuals transferred.

(d) Enforcement.

(1) Civil monetary penalties.

(A) A participating hospital that negligently violates a requirement of this section is subject

to a civil money penalty of not more than $50,000 (or not more than $25,000 in the case of a hospital with less than 100 beds) for each such violation. The provisions of section 1128A [42 USCS § 1320a-7a] (other than subsections (a) and (b)) shall apply to a civil money penalty under this subparagraph in the same manner as such provisions apply with respect to a penalty or proceeding under section 1128A(a)[42 USCS § 1320a-7a(a)].

(B) Subject to subparagraph (C), any physician who is responsible for the examination, treatment, or transfer of an individual in a participating hospital, including a physician on-call for the care of such an individual, and who negligently violates a requirement of this section, including a physician who—

(i) signs a certification under subsection (c)(1)(A) that the medical benefits reasonably to be expected from a transfer to another facility outweigh the risks associated with the transfer, if the physician knew or should have known that the benefits did not outweigh the risks, or

(ii) misrepresents an individual's condition or other information, including a hospital's obligations under this section,

is subject to a civil money penalty of not more than $50,000 for each such violation and, if the violation is gross and flagrant or is repeated, to exclusion from participation in this title and State health care programs. The provisions of section 1128A [42 USCS § 1320a-7a] (other than the first and second sentences of subsection (a) and

subsection (b)) shall apply to a civil money penalty and exclusion under this subparagraph in the same manner as such provisions apply with respect to a penalty, exclusion, or proceeding under section 1128A(a) [42 USCS § 1320a-7a(a)].

(C) If, after an initial examination, a physician determines that the individual requires the services of a physician listed by the hospital on its list of on-call physicians (required to be maintained under section 1866(a)(1)(I) [42 USCS § 1395cc(a)(1)(I)] and notifies the on-call physician and the on-call physician fails or refuses to appear within a reasonable period of time, and the physician orders the transfer of the individual because the physician determines that without the services of the on-call physician the benefits of transfer outweigh the risks of transfer, the physician authorizing the transfer shall not be subject to a penalty under subparagraph (B). However, the previous sentence shall not apply to the hospital or to the on-call physician who failed to refused to appear.

(2) Civil enforcement.

(A) Personal harm. Any individual who suffers personal harm as a direct result of a participating hospital's violation of a requirement of this section may, in a civil action against the participating hospital, obtain those damages available for personal injury under the law of the State in which the hospital is located, and such equitable relief as is appropriate.

(B) Financial loss to other medical facility. Any medical facility that suffers a financial loss as a direct result of a participating hospital's

violation of a requirement of this section may, in a civil action against the participating hospital, obtain those damages available for financial loss, under the law of the State in which the hospital is located, and such equitable relief as is appropriate.

(C) Limitations on actions. No action may be brought under this paragraph more than two years after the date of the violation with respect to which the action is brought.

(3) Consultation with peer review organizations. In considering allegations of violations of the requirements of this section in imposing sanctions under paragraph (1), the Secretary shall request the appropriate utilization and quality control peer review organization (with a contract under part B of title XI [42 USCS §§ 1320c et seq.]) to assess whether the individual involved had an emergency medical condition which had not been stabilized, and provide a report on its findings. Except in the case in which a delay would jeopardize the health or safety of individuals, the Secretary shall request such a review before effecting a sanction under paragraph (1) and shall provide a period of at least 60 days for such review.

(e) **Definitions.** In this section:

(1) The term "emergency medical condition" means—

(A) a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in —

(i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy,

(ii) serious impairment to bodily functions, or

(iii) serious dysfunction of any bodily organ or part; or

(B) with respect to a pregnant woman who is having contractions —

(i) that there is inadequate time to effect a safe transfer to another hospital before delivery, or

(ii) that transfer may pose a threat to the health or safety of the woman or the unborn child.

(2) The term "participating hospital" means hospital that has entered into a provider agreement under section 1866 [42 USCS § 1395cc].

(3)(A) The term "to stabilize" means, with respect to an emergency medical condition described in paragraph (1)(A), to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result or occur during from the transfer of the individual from a facility, or, with respect to an emergency medical condition described in paragraph (1)(B), to deliver (including the placenta).

(B) The term "stabilized" means, with respect to an emergency medical condition described in paragraph (1)(A), that no material deterioration

of the condition is likely, within reasonable medical probability, to result from or occur during the transfer of the individual from a facility, or, with respect to an emergency medical condition described in paragraph (1)(B), that the woman has delivered (including the placenta).

(4) The term "transfer" means the movement (including the discharge) of an individual outside a hospital's facilities at the direction of any person employed by (or affiliated or associated, directly or indirectly, with) the hospital, but does not include such a movement of an individual who (A) has been declared dead, or (B) leaves the facility without the permission of any such person.

(5) [Redesignated]

(6) The term "hospital" includes a rural primary care hospital (as defined in section 1861(mm)(1) [42 USCS § 1395x(mm)(1)]).

(f) Preemption. The provisions of this section do not preempt any State or local law requirement, except to the extent that the requirement directly conflicts with a requirement of this section.

(g) Nondiscrimination. A participating hospital that has specialized capabilities or facilities (such as burn units, shock-trauma units, neonatal intensive care units, or (with respect to rural areas) regional referral centers as identified by the Secretary in regulation) shall not refuse to accept an appropriate transfer of an individual who requires such specialized capabilities or facilities if the hospital has the capacity to treat the individual.

(h) No delay in examination or treatment. A participating hospital may not delay provision of an appropriate medical screening examination required under subsection (a) or further medical examination and treatment required under subsection

(b) in order to inquire about the individual's method of payment or insurance status.

(i) **Whistleblower protections.** A participating hospital may not penalize or take adverse action against a qualified medical person described in subsection (c)(1)(A)(iii) or a physician because the person or physician refuses to authorize the transfer of an individual with an emergency medical condition that has not been stabilized or against any hospital employee because the employee reports a violation of a requirement of this section.